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No. 18

SOME SOCIAL BIOLOGICAL ASPECTS OF THE VENEREAL DISEASES QUESTION.¹

By J. Burton Cleland, M.D., Ch.M. (Syd.),

The problems connected with the control of venereal disease are so intricate, and the issues at stake so vital that it is absolutely essential that the question should be looked at from every possible aspect, so as to ensure that the soundest policy is eventually adopted. With this object in view, I propose to outline some social-biological views that seem to me applicable to the relationships that should exist between the sexes, and so of primary importance in the problem of the control of venereal diseases.

The affection that should exist between husband and wife is evidently in some way directly connected with sex. That it is not primarily connected with actual sexual intercourse seems clearly indicated by analogies with some of the lower animals. A dog, for instance, seeks and obtains sexual intercourse with a bitch on heat without manifesting any temporary affection for his mate, and the courting of most animals cannot be considered as an indication of true affection; much less is there any permanent after-affection. The act accomplished, the bitch is to the dog no longer an object of particular attention. Further, the affection of the mother dog for her puppies, so self-denying and so great when these are young and helpless, ceases entirely when they have reached maturity. Contrasted with the dog, we see normally in human beings a deep affection binding together husband and wife apart from sexual gratification. In addition both parents, not the mother alone, protect and guard their children at least till these reach years of discretion. Why do these marked differences exist between man and the dog? The answer is, I think, clear when we consider the length of time required for the young human being to attain maturity, or even an age at which, though not matured, it might have some chance of fending for itself. In the dog, the care of the mother for a few months is quite sufficient to give a reasonable prospect of her progeny, or most of them, surviving. With the human being, 8 or 12 or more years must be considered necessary. How can the necessary care, during this long period, be ensured for the child? Can one parent alone on the average be reasonably expected to compass this result? Though the second question might perhaps be answered as being possible, any device by which the help of both parents could be ensured would obviously be of much greater service. The affection of both parents for their offspring has, I feel sure, been evolved to its usual very great degree, so that

their joint efforts may be directed towards the care of their children. But how is the father to be certainly associated in this way with the care of his children, having in view the long wait of nine months occupied by pregnancy before the first child appears, during which time, did nothing restrain him, he might pay court to many women, and in any case find it was a wise father that knew his own child? In the course of evolution, this difficulty was overcome, and to its overcoming must be attributed in great part our present highly complex social state, by the development of a great affection between the husband and wife, joining them together in bonds, biologically well-nigh unbreakable, to ensure that when the child was born both would work together in its interests. This affection of the father protects and helps to support the mother during pregnancy, and when the child is born is still devoted to her, in the interests of the child, the man fending off enemies and seeking the food supply for the mother and young, the mother immediately nursing and protecting the child. For the maintenance in nature of a species whose young mature so slowly and are helpless so long as is the case with man, some such devices as those outlined are essential. That they achieve their end is evident.

From the above outline another fact appears deducible: that man is a monogamous animal, and, in his evolved state, not naturally polygamous. The affection between particular individuals of opposite sexes is normally so much greater than that between either one of them and any other member of the opposite sex, that no room for doubt can exist that biologically we are not polygamous or polyandrous, unless when manifesting atavistic traits.

We seem entitled therefore to consider that, from a biological and evolutionary point of view, man is monogamous, and that, for the sake of the offspring, mating is of such a nature that the two individuals are bound permanently together to each other during life by a deep affection. Since this deep affection, of a kind *sui generis*, does not exist between individuals of the same sex—love such as that between David and Jonathan was of the kind due to long association with each other, of which other forms appear in love of home, of animals, of a particular routine, etc.—it must be considered as sexual in nature, and as in some way connected with sexual gratification. It may be said to be incapable of existence apart from sex, and hence not capable of manifestation by persons without a sex complex. Having in view the evolutionary scheme outlined above, I think we are justified in concluding that the converse of this proposition is also true, viz., that sexual intercourse of a normal, healthy, biological kind cannot take place without being associated with an abiding affection linking the couple together apart from sexual acts. If this view be considered reasonable, it is clear that promiscuous sexual intercourse, and sexual intercourse without

¹ Read at a Meeting of the New South Wales Branch of the British Medical Association on September 15, 1916.

affection and merely from lust, are both abnormal, and belong to the same category, though to a lesser degree, as bestiality and similar depravities. I maintain, in fact, that biologically it is unnatural and hurtful for sexual intercourse to occur unaccompanied by affection, and that prejugal intercourse of the kind associated with brothels is much more than "unnecessary" for the maintenance of a man's health.

If, then, biologically speaking, illicit intercourse is, considering man's highly evolved social state, unnatural and harmful, and its indulgence an atavistic trait reminiscent of the time when the human young was less helpless than now, how can its prevalence be diminished, and, with such diminution, the incidence of venereal diseases likewise? The answer will be found in using every possible means to induce earlier marriages, so that couples are joined together as soon after reaching maturity as possible, thereby lessening the period of temptation to pre-nuptial promiscuous intercourse. At present Wages Boards make awards estimated to be sufficient to maintain a man, his wife and two children. The single man with no responsibilities receives as much as the married man with a family. As the award is based on the amount required to keep a family of four, living as a family, not on the intrinsic value of work done alone, manifestly the single man thus paid is, from the State's point of view, overpaid inasmuch as he is shirking his responsibilities, or, in other words, is not giving to the State the full *quid pro quo* to which it is entitled for the wages the State has obtained for him. Though the single man cannot be paid less than the married one by his employer—if such were the case no married men would be employed whilst single ones were available—nevertheless he should be made to pay, by direct taxation, something as a penalty for neglecting his responsibilities to the community and in the hope that he may be thereby induced to accept those responsibilities. In other words, the single man, in the interests of the community as a whole, requires to be placed at some distinct disadvantage as long as he remains single, so as to induce him at as early a period as possible to marry. Similarly, the married man without a family should, though to a much less degree, suffer also some disability, even though the lack of family be not directly compassed by husband and wife.

The question of woman's work and woman's pay becomes here an important one. What inducement at present is there for many women to marry when husband and wife must live on an annual income equivalent only to that perhaps which each was earning separately? It must always be remembered that biologically woman's true sphere is found in the home and in looking after children. However valuable in individual cases her services along other lines may be to the community, the community must not in general allow anything to develop systematically that jeopardises home life or delays marriage at a suitable age. It is necessary to devise means either for discouraging women from remaining single or for encouraging them to marry early and bear children.

Though earlier marriages cannot be expected to abolish entirely venereal diseases, as unfortunately some of both sexes are sure to prove inconstant, such universal early marriage should tend materially to lessen the incidence of these diseases, and to diminish the length of the danger period before marriage has taken place. It is perhaps hardly realized that did no illicit intercourse occur throughout the world for a period say of five years only, gonorrhœa and syphilis would cease in all probability to exist by the organisms dying out in those infected before having had opportunities for infecting others.

To another aspect of the venereal question I desire also to draw attention. Amongst soldiers as amongst civilians, venereal diseases occur amongst two—or perhaps three—types of men, viz., the sexually vicious, the weak-willed and easily-corrupted, including those who have illicit intercourse chiefly because they think it "manly," and those who get intoxicated and know not what they do. There is hope for the two latter: the firstnamed will be a source of trouble and expense to the State probably throughout life. The harm he does far outweighs any good or the amount of work he performs. Such persons should be weeded out and permanently segregated and made to earn their own living under State guidance and discipline. In schools, especially boarding-schools, the same type occurs, and does incalculable damage to other boys of a pliable nature. At an early age the sexually vicious delights in repulsive sexual talk, and often seeks avenues of gratification of a hurtful nature. He delights in corrupting his fellows. If school-masters could devise means for detecting these boys and expelling them a source of grave trouble would be removed, and other boys tempted to follow the same course would be deterred and prevented from infecting most of the school. Some schools, both for boys and for girls, have had reputations for being permeated with such a vicious sexual leaven.

To sum up. If the State and the medical profession sincerely desire to control efficiently venereal diseases, the problem must be tackled in its entirety. Venereal diseases flourish *pari passu* with lax social morality. Such lax social morality in sexual matters is biologically unnatural and proportionately harmful. Earlier marriages unquestionably would result in lessening the amount of illicit sexual intercourse. Earlier marriage and the rearing of large families may be encouraged by granting special State rights to those marrying, such as diminished taxation and extra votes according to the number of children, and by making provision for a larger supply of domestic assistance to mothers brought about by the State requiring all women to serve a form of apprenticeship in housekeeping before being allowed to earn a living in pursuits other than those recognized to be essentially feminine. Remaining single may be discouraged by special taxation and by married men being chosen, other things being equal, for all public positions, and for promotion. By removing, or by pointing the finger of scorn at, the sexually vicious, whether at school or in after-life, their influence on others will be greatly lessened.

When measures such as these, aiming at the social dyscrasia that is the soil on which venereal diseases flourish, are combined with direct attacks on the diseases themselves, a successful issue to the campaign may be anticipated. Though it may be Utopian to expect that the community will adopt at once or as a whole the basic principles that have been here enunciated, it is the duty of our profession to weigh them carefully, to test them surely, and if they seem worthy of merit to press them on every possible occasion. To us the public look for guidance; though at first they may pay little heed to advice, perhaps unwelcome, if we reiterate again and again the views we know to be sound, they will at last credit them, or at least by our importunity open their ears to what we have to say.

SOME ASPECTS OF THE VENEREAL PROBLEM.

By Richard Arthur, M.A., M.D.,
Sydney.

There has recently come a welcome awakening of the public mind to the tremendous issues involved in the venereal problem. It is being realized that, of all the racial poisons which make for national degeneracy, there are none more potent in their effects than syphilis and gonorrhœa. And nowhere is there more urgent need for a serious consideration of this problem than in Australia, where the future holds the promise of grave and sinister possibilities that call for a numerous and virile population to meet them.

It is all to the good that the lay public is making a demand for knowledge on the subject. As long as every reference to sex matters except risqué jokes and suggestive flippancies was taboo, it was hopeless to look for any progress.

With this awakening of public interest, there devolves a great responsibility upon the medical profession. The people feel that only medical men can lighten their ignorance and offer a solution of the problem of the mitigation or prevention of this venereal plague, and I am convinced that the profession is prepared to accept this responsibility, and, as it has done in the past in other branches of preventive medicine, point out the way of national hygiene.

The subject can be discussed from two aspects:

- (1) The treatment of disease.
- (2) The prevention of disease.

With regard to the treatment of existing disease, the first essential for success is that sufferers should have knowledge of the advantage of early treatment and the serious results of procrastination and neglect.

If information on these points is widely spread, infected persons will be eager to obtain prompt and efficient treatment. The seriousness of their condition will be emphasized to them if they find that chemists and unqualified practitioners are forbidden by law to treat them. It is as absurd to permit such persons to undertake the care of venereal cases as it would be to allow them to have charge of small-pox

or plague patients, and the severest penalties should be enforced to put a stop to this.

The Health Board of California has adopted a plan which might well be followed in Australia. Posters stating briefly some of the results of syphilis and gonorrhœa, and urging the need of immediate treatment, with information as to the hospitals, etc., where such treatment can be obtained, are stuck up in urinals and other places frequented by men only.

Again, it is absolutely necessary that the average medical man must either be better equipped for the recognition and treatment of venereal diseases, or be prepared to hand over his cases to a specialist. There has been and undoubtedly still is much rule of thumb method in dealing with syphilis and gonorrhœa, with consequent unsatisfactory results. Too much is at stake to permit the continuance of happy-go-lucky varieties of treatment, which virtually are on a par with those of the chemist and quack.

But, before you can treat your patient, you must catch him, and in these enlightened days no civilized community should hesitate for a moment to enforce compulsory methods of the most drastic character to bring this about. A society has the right to protect its members against the risk of acquiring any contagious or infectious disease, and notification, and, when called for, isolation, are universally recognized as the most valuable measures in controlling these diseases. Why, then, draw the line at syphilis and gonorrhœa?

The recently-passed West Australian Act, which is also the basis for the recommendations of the Federal Committee, seems to be along rational and practical lines.

This legislation is neither harsh nor tyrannical. It simply says to the infected person: "You are suffering from a disease which is not only a menace to your own future, but which renders you a danger to your neighbour. It is both to your own interest and to that of the community that you should be promptly and efficiently treated, and you must go therefore to some hospital or doctor and continue treatment until you are no longer a danger to others. You are notified by a number to the Health Department, but if you fail to go on with treatment, your name is then to be given, and steps will be taken to prevent you from spreading infection." Much more drastic methods than these are put in force against lepers, although the risk of transference of leprosy is admittedly small.

It is possible that a few medical men might at first rebel against a notification system like this, but a sharp penalty for any omission would soon bring them to their senses.

On the other hand, if the methods recommended to press home on infected persons the seriousness of their condition were adopted, it is unlikely that many would refrain from submitting to treatment for fear of the remote eventuality that, owing to their neglect to present themselves for regular treatment, once it was begun, their names would be notified to an official who would himself be pledged to secrecy.

Let us consider now the subject of the prevention of disease. I remember hearing the late

King Edward ask the question at an International Hygiene Congress: "If these diseases are preventable, why are they not prevented?" His Majesty was not referring to venereal diseases; but the question is quite pertinent concerning them. Well, the answer is that for more than a century the European nations have been striving to minimize the venereal plague by various systems ensuring the medical inspection and certification of prostitutes and brothels, and to-day these systems are admitted to be failures, even by quondam defenders. Anyone who at the present time sets out to advocate a return to these discredited systems simply proves that he is ignorant of their history, and the position they now occupy.

On the other hand, the supporters of the "preventive" method of regular disinfection after illicit intercourse, which they state should be taught to all lads and young men, are evidently warranted in claiming for it a considerable degree of success. It is seemingly of much value when the procedure is carried out properly. However, it is not applicable in the large number of cases where those indulging in illicit connexion are under the influence of alcohol and therefore heedless of any possibility of infection.

But the mention of this "preventive" method raises a problem of immense magnitude for the medical profession.

The question that presents itself is:—Are medical men called upon to be ministers to vice? are they to adopt a frankly cynical attitude towards any standard of sexual morality? are they to argue that their first and only duty is to try and prevent disease, and that any ethical considerations lie entirely outside their province?

Such an attitude is a perfectly consistent one, but it must be carried to its logical conclusion, which undoubtedly is that there should be no differentiation between male and female in this respect.

The upholders of this doctrine postulate:—

(1) That a great majority of the men of any civilized community must and will have sexual intercourse outside of marriage.

(2) That a limited number of women, daughters of joy, eternal priestesses of humanity, or whatever you care to call them, must be set aside by some selective process to enable these men to gratify their sex instincts.

(3) That all other women, including the wives or future wives of the community, who are alleged to have little or no sexual desire, nevertheless owe what virtue they possess to the existence of the previous class.

Now I am prepared to admit that a considerable proportion of men of the present day will and do have illicit sexual indulgence, but it does not follow that this state of affairs is inevitable; and will always continue to be. Social evolution consists essentially of the imposition of more and more inhibitions upon the instincts of the primitive anarchic man. Communal life is only possible by the acceptance by the individual of restraints which run counter to his natural inclinations. The neolithic man probably killed his fellow without a qualm if he was angry

with him, or stole his goods, or violated his woman or women if he were stronger, honouring in every way the law that might is right. We have an admirable instance of reversion to type in the German of to-day.

But the average civilized man has acquired a social conscience, and has evolved certain ethical principles which shape his conduct even more than the inhibitions of the law. When our soldiers enter Germany, we do not expect that they will refrain from outraging the women there from fear of being shot, but because they will scorn to take advantage of the opportunities that may be offered.

But the most striking example of the inhibition of a natural instinct is seen in the way men are found willing to sacrifice their lives for an ideal. This is occurring daily at present when young men are cheerfully surrendering all the joy and pleasure that the future would hold for them for love of country or comrade.

Heroism has become a commonplace, and the human spirit has triumphed over pain and death, and has not the British tradition at the shipwreck, of "women and children first," stamped itself into the very fibre of the race?

In face then of such a marvellous overcoming of the strongest instinct in human nature—the will to live—are we warranted in taking up an absolutely pessimistic attitude as regards a similar control of the sex instinct?

Even at present this instinct has to accept certain limitations. The crime of rape is punished very severely, and girls below a certain age are protected by law. And further, the social conscience condemns the seduction of a woman, though contrariwise the oftines product of this, the prostitute, is acclaimed as a social necessity.

I am firmly convinced that in the future there will arise, as a result of a further evolution of social morality, a much greater prevalence of continence among young men, with a corresponding diminution of prostitution and venereal disease.

The proof of the possibility of this lies in the fact that one half of the individuals in civilized communities have attained in a greater or lesser degree to such a control. There is no warrant for the belief that continence is a natural trait in women. It is one which has been acquired through social pressure, and the demand of the male for chastity in the woman with whom he mates.

The defenders of the double standard of sexual morality advance the claim that while sex desire is active and almost irresistible in the male, it is weak and sometimes non-existent in the female, or at any rate is always latent, and needs to be roused by intercourse. Now this is a theory which is open to grave suspicion as being put forward to bolster up a questionable case.

Havelock Ellis, discussing it, says:—"It seems to have been reserved for the nineteenth century to state that women are apt to be congenitally incapable of experiencing complete sexual satisfaction and peculiarly liable to sexual anaesthesia," and he quotes a number of authorities who combat this view.

I was once informed by a medical man that some middle-aged spinsters of high and strong character, engaged in strenuous work, had confided to him that sometimes they were racked with sexual desire, and had felt tempted to go out and offer themselves to the first man they met.

But let us grant that sex desire is latent in the female, in this way differentiating her from the male. What, however, is to be the guiding principle for women in whom desire has been roused, as in the case of widows and wives who are temporarily separated from their husbands? How can a repression of passion be demanded from them when it is not thought feasible in the case of men?

I say emphatically that if we are to advocate licensed brothels where men can have intercourse with a hypothetical freedom from the danger of venereal infection, it is equally reasonable to propose the establishment of similar institutions where women can go and obtain relief for this natural instinct.

Again, if we are going to instruct young men in the use of "preventives," our girls are surely entitled also to be guarded against the risks of promiscuous intercourse? Why should we not seek to make it as safe for them as for their brothers?

And if we as a profession concede that men must have sexual indulgence at any cost, is it not our duty, as far as we can, to protect their partners from some of the attendant dangers?

By far the most tragic episode in any girl's life is when she becomes pregnant as the result of illicit intercourse. To all of us must have come at some time or other the agonized appeal from a young woman to rid her of the hateful burden that was bringing her life crashing down in ruin.

I have never yielded to this appeal, and yet I will confess that sometimes I have been sorely tempted, and felt that the recording angel might drop a tear on the page of my wrongdoing.

We rightly feel ourselves bound by the command "Thou shalt not kill," and yet we must know when we refuse this request that we are not only confirming the penalty of shame and social ostracism, but we are sometimes relegating the woman to a lingering death from septicæmia.

I notice that a Judge a short time ago incurred the reprobation of medical opinion because he suggested that the practice of abortion might under certain conditions be legalized. Nevertheless it is somewhat anomalous that we should take such high moral ground in connexion with this matter while we seek to make the path easy and safe for fornication.

If we are called upon to render vice hygienic for men, why should we not on the other hand be willing to familiarise young women with the idea that safety from the tragic happening of illegitimate pregnancy can be found in the condom, and advise them to insist upon its use. If the condom will protect the man against syphilis it will equally guard the woman against pregnancy.

These arguments of course are merely the *reductio ad absurdum*. The truth is that the day of the double standard of sexual morality is passing. We can only have it one way or the other; either we

must grant the equal right of promiscuous intercourse to women, and revert to the ethics of the barnyard, or we must concede that the double standard has no foundation in science or logic, and should denounce it accordingly.

Man in the past has imposed upon women a moral code which he refused to subscribe to himself, and has excused himself by pleading that his passions were very strong, and his will in this regard very weak, while with women it was *vice versa*.

But I maintain that it is not the duty of the medical profession to pander to this plea, nor do I subscribe to the doctrine that a medical man should play the rôle of a pimp to prostitution. Can one conceive of a more disgusting and degrading occupation for a doctor than that of inspecting prostitutes to ascertain if they are in a fit state to ply their trade, or of giving systematic instruction to young men in the use of preventives?

Nevertheless, in spite of these convictions, I will admit that the dilemma is a cruel one, especially in time of war. We have learnt that a tremendous number of Australian troops were more or less incapacitated through venereal disease, and that, had these men been available, the history of the Dardanelles campaign might have been very different. If we advance the principle of tolerating evil that good may come, we can only fall back on the plea of the German Chancellor: "We are in a state of necessity, and necessity knows no law. The wrong which we are about to do we will seek to atone for after the war." This, of course, is pure casuistry, and I am only stating the position and not defending it. I would say in passing that I believe that the military authorities both here and in Egypt are much to blame for the prevalence of disease. If they had minimized or abolished the sale of alcohol, placed the training camps in districts remote from any large town, and had the troops addressed systematically and seriously on the evils and dangers of illicit intercourse, much of the trouble and wastage could have been prevented.

Under normal circumstances, I have no doubt whatever as to what our position should be. We cannot serve the two masters of morality and vice. We must throw ourselves whole-heartedly into the service of one or the other. If we are to be hygienists pure and simple, and let morality go to the devil, if we are to be on the side of licensed brothels and preventives, then it is a hypocritical farce to talk of education in sex, and of the advantages of continence.

On the contrary, if we have any belief in the value of instruction, warning and inspiration, our common sense must teach us that those whom we seek to reach by these methods must regard us as doing so with our tongue in our cheek, when *pari passu* we strive to make the way of illicit intercourse safe and easy for them.

I have been for many years a firm believer in the necessity for letting air and light into this subject of sex relations, and I am convinced that we are standing to-day at the opening of a new era, the causes of which are the intellectual emancipation of women, the increasing influence of eugenics, the disappearance of the mock modesty that banned all

consideration and discussion of one of the greatest of natural functions, and the growing public concern at the menace of venereal disease. These causes will bring about—very slowly no doubt—a revolution in the mental attitude of men towards illicit intercourse.

Dr. Butler, once Master of Trinity and Headmaster of Harrow, pointed out nearly forty years ago what seems to me the first and most promising line of attack. He wrote: "A wise man should, in my judgement, strive to make his boys feel, not so much that impurity among them is very wicked—that they take for granted—but that it is very disgusting, something not to be tolerated in a school of gentlemen, something to be put down by kicks and blows, and banishment from home games and suppers and the like, rather than by appeals and confessions and special services and prayers. In an immature society like that of boys in whom the sense of honour and propriety is far in advance of the sense of moral right, lying and bullying are more likely to be shunned because they are disgraceful than because they are wicked, and it may be that this is the side on which the fortress of impurity also is the most assailable."

In the same way I believe that a new moral standard can be created among lads and men. Teach them, not so much that fornication is dangerous as that it is dishonourable; that it is a cowardly and despicable thing to take advantage of the ignorance, the weakness, or the affection of a girl; that it is degrading to go out and buy the body of a woman in the market place; that it is infamous that a pariah class of other men's daughters and sisters should exist to minister to their lusts; and that it is not a fair bargain to demand chastity in the woman they marry while they go to her sodden in debauchery, and it may be infected with some foul disease that will blast her life and the lives of her unborn children.

If there is that in a seemingly degraded and drunken fireman which restrains him from a mad rush for the boats, and enables him to go down to death without question for some unknown woman and child, so by the slow growth of a similar code of honour and sacrifice with regard to sex, the young man, in Huxley's words, "will learn to call his passions to heel and scorn to bring shame or physical hurt on any women."

There is, I am convinced, within the Anglo-Saxon lad at least, a latent chivalry and sense of honour which only needs to be evoked to change incalculably his attitude towards womanhood. Till now, the appeal to that has not been made, a false standard of manhood has been tacitly given and accepted, the "wild oats" doctrine has been winked at or jestingly repudiated, and when our young men respond to this environment and follow the powerful promptings of their sex nature, we assert that this is inevitable, and debate how they do this with physical immunity.

I prefer to maintain the possibility of a clean and chivalrous manhood, and if the ideal seems altogether visionary to-day, that is no reason why those of us who hope for the coming in some distant future of a purer and nobler race should not strive to hasten the dawning of that fairer day.

SOME CASES IN THE 1915-1916 EPIDEMIC OF INFANTILE PARALYSIS.

By R. B. Wade, M.D.,

Hon. Surgeon, Royal Alexandra Hospital for Sick Children, Camperdown, New South Wales.

This report is based on 69 cases of infantile paralysis, occurring during the summer months of late 1915 and early 1916, and treated at the Department for Medical Gymnastics at the Children's Hospital, Sydney, after the acute stage was passed.

The outstanding feature was the unusual number of recoveries that ensued; 35 patients were discharged as cured, four, at present under treatment, show signs of gaining complete power again, and three others, who were discharged as improved, owing to a shortage of masseuses (the Department was partially shut down for a time), are now recovered. In all there was a recovery rate of 60%.

By the term "recovery" is meant that all the affected muscles had regained power so far that they were able to fulfil their normal function. Thus, in a quadriceps paralysis, the child was not only able to hold the leg out in an extended position, but was able to raise itself from a squatting position to the upright, thus lifting the whole body weight; in a deltoid paralysis it was able to abduct the arm from the side while lifting a weight; in the case of the invertors and evertors of the foot walking was possible on the outer and inner edge of the foot respectively; similarly with other groups of muscles.

The only indication of the trouble that was left was in some wasting of the limb when compared with the other side, and some persistent coldness of the skin over the affected limbs.

Mr. J. B. Trivett, the Government Statistician for New South Wales, has kindly supplied me with the reported figures for this State of this epidemic. There was a total of 355 cases, with 30 deaths, or a mortality of 8.4%. Compared with other reported epidemics, this is a low mortality-rate, while the recovery rate is large. Thus, Wickman reports 868 cases, with 16.7% mortality and 44% recoveries; Leegard reports 577 cases, with 14.56% mortality and 26% recoveries; Zappert reports 266 cases, with 10.8% mortality and 15% recoveries. Other reported epidemics give a death-rate varying from 11.7% to 22.5%, but no figures are given as to the number of muscular recoveries.

It may be of some interest to attempt to analyse the factors that may have caused this unusually large recovery-rate.

Though I saw only a few of these cases during the acute stage, many of them were in-patients at the Hospital, and their history sheets show nothing by which their future fate could be gauged; they were cases of moderate intensity, the fever lasting for four or five days, the local tenderness being very marked, and the primary involvement generally being considerable; just the average type of case.

Though I have been told that many were of the cerebral type, the type that lends itself best to recovery, all the cases treated at the Department were of the lower motor segment variety.

In the cases treated as in-patients, there was, as usual, the quick recovery in six to eight weeks of a

great part of the primary paralysis, leaving, as usual, more or less residual paralysis that showed no tendency to quick recovery.

These groups of muscles with residual paralysis, in some cases, showed no twitch at all for perhaps three to six months, after which recovery progressed slowly, until function was regained.

There was really nothing in the clinical appearance except the recovery to indicate that the epidemic was of less virulence than usual, though the fact of the low mortality-rate shows that the virulence of the infection was attenuated.

The treatment consisted mainly in placing the affected groups of muscles in a position of rest by means of splints, and keeping them at rest with short intervals of freedom from the splint, gradually increasing as strength developed.

The splinting serves two purposes; it relaxes the affected muscles and prevents them from being over-stretched, a condition rendering their recovery impossible, and it prevents the healthy opponents from shortening up, with resultant deformities.

These effects can be obtained with very simple appliances. Thus, if the thigh muscles, the quadriceps, are affected, a straight back splint can be used; if the hamstrings, the same, padded at the knee, to allow of their relaxation; the foot, if completely affected, must be kept at a right angle; if the invertors of the foot only are paralysed, a Dupuytren's splint is applied to the inside of the leg; if the evertors only, the same to the outside. In the majority of cases the thigh and leg muscles are all affected, and, consequently, the most convenient splint is a long trough of 26 gauge sheet iron, extending from the buttocks and ending in a right-angled piece at the foot. This splint can also be made of celluloid, moulded on to a plaster cast of the limb, of leather, poroplastic felt, or even, for very small children, of cardboard.

The only muscles about the hip that need much care are the rotators, and they can be controlled by tying the trough to a pillow; the flexors of the thigh, the most important for subsequent walking, are fortunately but seldom affected permanently, and recover without much attention. For the body, where the *erector spinae* and the abdominal muscles are involved a light poroplastic felt jacket, extending up to the neck if required was found of most value.

When the deltoid is affected, a double trough splint of 26 gauge sheet iron, connected by an iron bar, the large trough to embrace the side of the chest and the other for the upper arm, to hold it at a right angle from the body, is found to be of service. When the forearm or hand is affected, in addition, a further prolongation from the trough, to hold the forearm flexed and the hand flat, is used. Most children soon become accustomed to this somewhat clumsy apparatus for day and night wear. For those who object to it a pillow tied under the arm forms a passable substitute; similar results can be obtained with cardboard splints in the very young. The splints are worn continuously; at first with daily remissions while the limb is massaged. When the muscles show signs of some recovery the patients

are encouraged to perform any movement they are capable of; they are allowed to move the limb over a piece of cardboard powdered to eliminate the action of gravity. For example, the child with a paralysed quadriceps would lie on the side and flex and extend the leg. When the deltoid is affected, it would lie on the back and abduct the arm. The movements are thus graduated to the capacity of the muscles, until the child had power to lift the limb against the action of gravity.

At the same time, as soon as the unaffected muscles are able to do work and the child shows an inclination to exercise them, free use is permitted; but the affected muscles are still restrained by splints. Thus, with a child with affected quadriceps or hamstrings, or both, showing an inclination to walk, it is permitted to do so, while wearing a leather cast around the leg from the buttocks to below the calf. If the invertors or evertors are out of action, a side iron and the boot, built up on the side indicated, are applied. When the muscle group is able to do without the help of the splint for a brief time, it is encouraged to do so and the splint is left off for short periods, gradually increasing during the day. It is worn all night, until recovery is sufficiently advanced to warrant discarding them altogether.

It was found that if the muscles were only occasionally overstretched by the manipulations of the joints during massage no harm resulted, provided that they were kept in splints for the rest of the day. This is contrary to the usual teaching.

There were several cases that showed no improvement at all until splints were applied to keep the muscles relaxed; they then made a quick recovery. This was noticeably so in the case of paralysis of the deltoids, quadriceps and invertors of the foot.

In addition to this splinting and muscle education, the affected groups were massaged.

No electrical treatment of any kind was used.

It may be asked how far the treatment was responsible for the results. Probably only in so far as the limbs were placed in the most suitable position for recovery, and this was very noticeable in some of them, as mentioned above, for no trace of recovery was detected until splints were applied. The probability is that, though many of the muscles would have recovered without any treatment, there were many that would not have done so without the aid they received.

Reviews.

DAMAGED GOODS.

We have received from Messrs. J. C. Williamson, Limited, a copy of Brieux's play, "Damaged Goods," translated into English, with a Preface by G. Bernard Shaw, and a Foreword by Mrs. Bernard Shaw.¹ From a literary point of view the play and both prefaces are of a high order, and therefore the lessons which the three authors have to deliver are elegantly dressed. A message given in indifferent

¹ Damaged Goods: A Play by Brieux, Member of the French Academy. Translated by John Pollock, with a Preface by Bernard Shaw and a Foreword by Mrs. Bernard Shaw; Demi Svo., pp. 63.

language could not serve its purpose well. The contents of the play, deprived of its smooth wording and skilled expression, is less palatable; but there are things in real life that are unpleasant. Some of us may be inclined to advocate an attempt to smooth over the ugly, the unpleasant, and to cover the hideous with an artificial, beautiful covering. The author and his introducers recognize that any attempt of this kind to mask the truth must be condemned, because the time will come when the covering is torn from reality, and truth, naked and unadorned, may be forced to their danger on countless human beings. The play deals with a man about to be married. He has contracted syphilis after having indulged in illicit sexual intercourse with a so-called "square girl." He claims that he has led a most exemplary life, having had only two mistresses, both of whom he chose because he regarded them to be safe from the risk of infection. Incidentally, he explains the means he had adopted to keep these women free from infection—for his own safety. The doctor he consults warns him that he must not marry, and explains the situation to him thoroughly. The man has made up his mind that he will run the risk of infecting his future wife and any children she may bear him. He compromises between an immediate marriage and the doctor's uncompromising three or four years of delay, and marries in six months. The result is, of course, disaster. The infant is born with congenital syphilis, and the wife is presumably untreated. Her father seeks the doctor for proof of the nature of the infection. The doctor refuses to give this. The father is indignant, full of vengeance and desperate. Until the doctor demonstrates to him that one difference between his son-in-law and himself is that the former has been unlucky in having contracted an infection, while he, after having exposed himself in his youth to the same dangers, has been fortunate to escape the disastrous consequences. Records of various forms of venereal infections, not in a pathological, but in a sociological, sense are displayed for the benefit of the father of the innocent girl victim of this "moral" young husband. The book or play thus contains two direct lessons and a number of minor ones. The first is that a man who runs the risk of infecting his innocent wife with a foul disease is the worst kind of criminal. The second is that much venereal disease is spread about broadcast because the fools or beasts who spread it were ill-informed of the dangers they were running. Some of the facts in the play are not easily proved. Some of the philosophy is a little one-sided. But, in the main, the doctrines will stand the most minute criticism. There are two questions to be answered before the book or the play can be recommended to the public for general consumption. Is the theatre the place for delivering a lesson of this kind? Bernard Shaw believes that the average young man living in lonely lodgings takes his only artistic recreation in the theatre. Perhaps. But would not this lesson reach a wider public and be driven home more generally and in a more telling manner when read than when staged? It is a difficult question to decide. The second question is: Will the play act as a deterrent, either in the direction of inducing men to be more continent or in the direction of preventing men from committing the heinous crime of marrying a pure woman when infected with a venereal disease? We find difficulty in replying to this question in the affirmative. But the doubt should not determine us from trying the experiment. The problems are so serious, the results of venereal diseases so ghastly that no possible prophylactic measure should be passed by unused. In the play the doctor tells the young man what to teach to his sons, when he has sons to teach. His doctrine may be summarized as follows: Be good; and if you cannot be good be careful. Some years ago, August Forel, the Swiss psychiatrist and scientist, who had given much consideration to the sexual problems of the human race, sought to bring out an English translation of his book, "The Sexual Question." His attempts to find a competent translator were at first unsuccessful, and he ascribed this to "English prudery." Books on sexual matters and plays with a definite moral tendency have been banned, while the coarse trend of the day toward suggestiveness and sensuality has been untouched. We are passing from this extreme to the other, and it may be asked whether the public is not being led to speak and think a little too much about venereal diseases. The play is by a Frenchman, a very artistic Frenchman. But it has been said that, while the

Englishman's national game is football, the national game of the French is love. Are we not running some risk of creating a similar tendency in Australia by fanning this appetite and by giving undue and even exaggerated prominence to the sexual and venereal questions?

University Intelligence.

THE UNIVERSITY OF SYDNEY.

A monthly meeting of the Senate of the University of Sydney was held at University Chambers, Phillip Street, Sydney, on October 9, 1916.

A letter was received from the subscribers of the Arthur Oakes Memorial Prize Fund, in reference to the establishment of an annual prize in the Department of Economics, in memory of the late Arthur Wellesley Oakes, M.A., to be called "The Arthur Oakes Memorial Prize." It was resolved that a letter of thanks be forwarded, and that it be referred to the Faculty of Arts to draw up the conditions of award for the prize.

Letters of thanks were ordered to be sent to the following donors: (i.) Dr. and Mrs. H. G. Chapman for dried specimens of 977 Australian plants, and (ii.) Mr. Rowe for manuscripts, "Texts from Egyptian Stelæ of the Earliest Period."

The Warden reported that Mr. K. L. Barry, Busby scholar, had resigned his scholarship on account of his proceeding to England for enlistment, and, on the recommendation of Professor Fawcett, it was resolved that Mr. J. C. Green be appointed for the remainder of the scholarship term.

It was resolved that Mr. G. F. Sutherland, P. N. Russell Lecturer and Demonstrator, be appointed Acting-Professor of Mechanical Engineering, during the absence of Professor Barraclough.

The degree of Doctor of Laws was conferred in person upon Francis Mephan Gellatly.

On the recommendation of the Faculty of Arts, it was resolved that the Thomas Henry Coulson Scholarship be awarded in Course II. to a student of six terms' standing in the Faculty of Arts for Distinction in the study of English Language and Literature for one year.

THE STUDY OF THE INTERNAL SECRETIONS.

An association for the study of the internal secretions was founded in June, 1915, in Detroit, U.S.A. The object of this association is to collect, collate and evaluate the reports of investigations on the physiology and pathology of the ductless glands. The means selected to achieve this end included the publication of a periodical, the establishment of a lending library, the institution of "round-table discussions," the appointments of investigation committees and the holding of annual meetings. The first issue of the official organ of the Association, bearing the name of *The Link*, was issued in September, 1916. Its contents are largely explanatory matter and propaganda. Those who are interested in this work are invited to join the Association and to correspond with the Secretary of the Organizing Committee, Dr. Henry R. Harrower, Glendale, Los Angeles, California, U.S.A.

OBSTETRIC PRACTICE.

Dr. R. A. Parker has called our attention to the fact that in his letter published in our issue of October 21, 1916, he intended to refer to the use of *eusol* as a vaginal douch in septic cases, and not *eneosol*. He informs us that *eusol* is a preparation containing equal parts of chloride of lime and boric acid in solution. He adds that this preparation has proved most satisfactory in all the cases of septic wounds in which he has used it. *Enecol* is the synonym for mercury salicyl-arsenate. *Eusol* is prepared by dissolving 25 grammes of eupad powder in 1 litre of water. Eupad consists of equal weights of boric acid and bleaching powder. The former is in sufficient excess to set free the hypochlorous acid in the solution.

The Medical Journal of Australia.

SATURDAY, OCTOBER 28, 1916.

The Limitation of Venereal Infection.

The Commonwealth of Australia, in common with the greater part of the civilized world, has been forced to recognize the fact that venereal diseases are very widespread, and that the amount of physical and mental disability arising from this cause is well-nigh immeasurable. Something must be done to cope with the problems involved. Practical measures are taken with the object of stamping out tuberculosis and other dangerous infective diseases, and it is quite obvious that the same obligation rests on the health authority in connexion with syphilis and gonorrhœa. In the case of tuberculosis, diphtheria, cerebro-spinal meningitis and other diseases occurring in epidemic form, the medical profession realizes its duty of collaborating with the health authority in the work of prevention. Were the moral aspect of venereal diseases non-existent, no special difficulties would present themselves, and it is probable that a greater measure of success would attend the endeavours to gain a complete control over these than over other infections. The difficulty which threatens to render all attempts to stamp out these infections vain is to be sought in the attitude of the purist as contrasted to that of the hygienist.

In all the controversies on venereal infections men and women have found it impossible to refrain from the introduction of a great side-issue. The sexual question is in reality quite distinct from that of the prevention of a disease. A perusal of a highly interesting and important discussion which has been spread over two evening meetings of the New South Wales Branch of the British Medical Association will reveal this fact very distinctly. The Departmental Committee in dealing with venereal diseases recommends education of boys and girls in sexual matters, teaching them continence and so forth as prophylactic measures against infection. Physiological matters should no doubt be taught to chil-

dren as a part of their moral up-bringing, and should be done by the parents, or with the consent of the parents by someone else. But as a practical measure in preventive medicine, we fail to recognize its significance. To teach children pathology and the ætiology of disease is surely a dangerous expedient, since the knowledge that could be imparted would be but superficial, and the result of the misunderstandings that would most certainly arise cannot be anticipated. Similarly the proposal of early marriage does not appear to be commendable, since it aims at the reduction of illicit sexual intercourse and not necessarily of infection. The early marriage of infected persons would probably be a fruitful means of spreading infection.

In the case of other infections, prophylaxis is directed along definite channels. The incidence of the infection has to be ascertained, and this is done by common consent by notification. No other method can offer so secure a basis on which preventive measures can be built. The object of notification is, or should be, to trace the source of infection and to cut this source off, so that no further damage can be done. Rabies was stamped out in England by the notification of every case of hydrophobia in dogs and the destruction of every infected dog. Complications arise in diseases in which the infection is passed on through an intermediate host. In the case of syphilis and gonorrhœa the matter is simple and the infection direct. A second complication that gives some difficulty in regard to diseases such as enteric fever is the existence of the carrier state. For practical purposes every person harbouring a gonococcus or a spirochæte may be regarded as infected, and consequently the second complication disappears in regard to these diseases. We have a simple task to perform, if the community is in earnest and desires to control these devastating infections. By notification and tracing the sources of infection every dangerous nidus could be ascertained. It is impossible to consider isolation as a practical measure to render the infected safe for the community at all events in regard to syphilis. The only alternative which promises a reasonable measure of success is compulsory treatment until the infectivity has been combatted. In other words,

the provisions of the Western Australian Health Act Amendment Act, and indeed the provisions of the Queensland Health Act, 1900-1911, to which our attention has been drawn, should suffice to bring these diseases under control, provided that anonymous notification proves to be efficacious. It appears to us that confidential notification to the chief medical health authority by name would promise more. Moreover, in a matter of national importance of this kind the legislative control should be uniform throughout the Commonwealth, and in our opinion the provisions should be administered from one central authority.

Auxiliary measures have been suggested in large number. Modern scientific methods have made diagnosis more accurate, and have placed into our hands an index of the progress of cure. As time proceeds, no doubt these methods will become still more accurate. The progress of science has completely changed the significance of the registration of brothels and the inspection of prostitutes. In the course of the tracing of sources of infection, the health authority would receive valuable assistance were houses licensed and the persons of both sexes using these houses subjected to adequate medical examination. It must be recognized that these expedients would only reach a small proportion of the danger spots. No doubt the knowledge that the inmates of licensed houses could be regarded as reasonably safe would deflect many from other channels to them. Nevertheless, some means should be adopted to lessen the danger of the unregistered person outside the scope of control. Ignorance and possibly indifference place the amateur almost beyond reach, and consequently the advocacy of the condom, which has so eloquent a champion in Dr. Worrall, should be employed. It is possible that its use might become common, were the legislative restrictions removed, but too much reliance should not be placed on the probability of inducing foolish young men (and vicious old ones, too) to seek its safety.

If the public would concern itself with the moral aspect of the sexual question and leave the hygienic side to the health authority and the medical profession, much could be done. Otherwise it seems

probable that the world will remain unaltered, notwithstanding all the ink and breath that has been expended on these subjects. Too much talk may even do harm.

DIABETIC COMA.

Stadelmann was the first to draw attention to the similarity of the symptom-complex of diabetic coma to that of acid intoxication, as known from experimental studies upon animals. The peculiar dyspnoea, the accelerated pulse, the fall of temperature and the respiratory failure, antecedent to the cardiac paralysis, which are present in both conditions, invited the comparison. Already aware that the diabetic patient produced large amounts of organic acids, he put forward the hypothesis that diabetic coma is due to poisoning by the acids accumulated in the blood. The estimations that Stadelmann had made of the amounts of the principal bases and of the inorganic acids plus uric and hippuric acids had impressed upon him the magnitude of the formation of the four carbon atom acids. The greater quantity of ammonia, perhaps twenty times that found in the healthy individual, recalled to his mind the manner in which man, in common with the carnivorous animals, protects his tissues against a higher acid reaction. Stadelmann had noted the absence of the development of a claret colour on the addition of ferric chloride to the urine of a comatose diabetic patient. From this observation he inferred the absence of any considerable amount of acetoacetic acid and ascribed the poisoning chiefly to β -oxybutyric acid. Acetone was assumed to be a secondary product formed by the reaction between the alkali of the blood and the four carbon atom acids. Acetone and acetoacetic acid were regarded as unimportant, slightly toxic agents, which played a subsidiary part in the poisoning, mainly due to β -oxybutyric acid.

The amount of oxybutyric acid that can be formed and excreted from the body in the diabetic state is large. The observations of W. H. Hurttley make it clear that many hundreds of grammes appear in the urine during a month. This quantity is obviously more than equivalent to the total amount of the fixed alkali and base of the blood. The human body can, however, utilize ammonia to neutralize this acid, and can thus protect the bases that regulate so many vital phenomena. Hurttley shows that a diabetic patient can excrete 600 grammes of β -oxybutyric acid a month for several months without suffering from coma. It was pointed out by Magnus Levy that it is the acid not removed from the blood and not the acid excreted which produces coma. Since bases are found in the urine combined with the organic acids, the loss of these bases might conceivably lead to the production of an acid state. The direct determination of the degree of acidity can now be made by physical means. The data collected by these methods show that the blood of the diabetic patient has the same concentration of hydrogen ions as the

blood of the healthy person. During diabetic coma the concentration of hydrogen ions is increased, but not to a considerable extent. β -oxybutyric acid is a weak acid with a low co-efficient of dissociation, so that high concentrations, considerably more than those found, would be required to produce an acid intoxication of equal severity to that leading to fatal consequences brought about by hydrochloric acid. As a matter of fact, when subjected to rigid analysis, the theory of acid intoxication by β -oxybutyric acid falls to the ground. The blood is not sufficiently acid in diabetes or in diabetic coma to kill the cells of the tissues, and organic acids do not accumulate in the blood in sufficient quantity to raise the concentration of hydrogen ions to a toxic level. Attention must therefore be directed to the poisonous action of these bodies, apart from their effects as acids. Hurtleigh believes that aceto-acetic acid is toxic in the diabetic patient, and ascribes to this body the ills of diabetic coma.

One further character of the comatose state in the diabetic person deserves mention, viz., the diminution of carbon dioxide in the blood. The amount of this gas held in the blood may be less than one-half of that in the blood of healthy persons. In the normal individual the amount of carbon dioxide in solution is a function of the alkalescence of the blood as measured by titration. In diabetic coma this relation is lost. The carbon dioxide is reduced much more than the alkalescence determined by titration. When a limb is ligatured in the comatose diabetic person, the blood in the congested area takes up as much carbon dioxide as normal blood of the same alkaline reactivity. It would thus appear that the blood in the comatose patient has not been fully saturated with carbon dioxide. The same phenomenon can be demonstrated by shaking the blood of a comatose diabetic patient with air containing 4 to 6% of carbon dioxide when the blood takes up carbon dioxide freely. The meaning of this reduction of carbon dioxide in the venous blood is as yet unknown. As a result of this diminution, the percentage of carbon dioxide in the alveolar air of comatose diabetic patients is markedly lessened. It has been stated that the diminution in the carbon dioxide precedes the advent of coma. If this be correct, analysis of the alveolar air would provide a simple means of detecting the onset of coma.

TYPHOID AND PARATYPHOID FEVERS AMONG OUR TROOPS.

Through the kindness of Major Hugh R. G. Poate, the Honorary Secretary of the Anzac Medical Association, we have received a valuable paper on "The Distribution of Typhoid and Paratyphoid Infections amongst Enteric Fevers at Mudros," by Lieutenant Colonel C. J. Martin and Major W. G. D. Upjohn. This paper was read at a meeting of the Anzac Medical Association in Cairo on February 20, 1916. It has been published in the *British Medical Journal* of September 2, 1916, and is therefore available for every member of the British Medical Association. Were it not for this fact we should have wished to have published this excellent communication.

The authors have investigated the serum reactions in the case of men ill with various illnesses, and have been able to determine with a considerable degree of accuracy the prevalence of pure enteric fever, of paratyphoid A and of paratyphoid B fevers. Out of a total of 627 cases, 163 yielded serum which failed to agglutinate one or other of the bacilli in the minimum dilution used. These cases were either instances of diseases other than typhoid or paratyphoid fevers, or were in the very early stages of these infections, before an agglutination reaction could be expected. They therefore limited their close attention to the remaining 464 cases, in which an agglutination reaction was obtained. The serum gave a positive response to the *bacillus paratyphosus* A in 213 cases, and the diagnosis was made accordingly. There were 113 cases of definite paratyphoid B fever. A positive agglutination of *bacillus typhosus* does not, of necessity, under the conditions obtaining among our troops, indicate enteric fever, since the majority of the men have been inoculated against this disease. It has been shown that, notwithstanding the fact that 138 samples of serum caused an agglutination of Eberth's bacillus, only 25 cases of true enteric fever existed. The authors calculate that the incidence of true enteric fever in Egypt and Gallipoli, from the commencement of the war up to the middle of December, 1915, was less than 0.5% of the total amount of sickness. This low morbidity is attributed to antityphoid inoculation. On the other hand, the prevalence of paratyphoid fevers has led to the approval of their recommendation that a vaccine containing *bacillus typhosus* and *bacillus paratyphosus* should be used for inoculation purposes. Even when the vaccine was a simple typhoid one, the agglutination reactions were markedly interfered with, and diagnosis by this means was not easy. It is surprising to learn that the typhoid agglutinins had disappeared in some of the cases dealt with after six or twelve months. After subsequent inoculation with a paratyphoid vaccine a group reaction appears to have been awakened. If the agglutination reaction is to be employed as a measure of immunity, it would seem as if some form of provocation were required to revive the output of antibody. The authors have not dealt with this aspect of the subject; but, in view of the practical importance of the immunizing power of prophylactic vaccines, it would well repay a searching enquiry to ascertain how far the known antibody formation runs parallel with the existing protection. The possibility that antibodies other than agglutinins might be utilized for this measurement should not be lost sight of, although the work of Leishman and others suggests that the agglutinins give the most accurate information.

A Correction.

Dr. S. Harry Harris has called our attention to an error in his paper on "Some Observations on Acute Renal Infection in Pregnancy and the Puerperium," p. 291, which appeared on October 7, 1916. In the twelfth line from the top of the right-hand column "full of pus and bacteria" should read "free from pus and bacteria." The sentence has reference to eleven cases of hydronephrosis due to obstruction of the ureter, in which the condition was dealt with before any secondary pyelitis developed.

Abstracts from Current Medical Literature.

DERMATOLOGY.

(151) Epidermolysis Bullosa.

A. W. Nelson records a case of epidermolysis bullosa in a Cuban boy aged 11 years (*Urologic and Cutaneous Review*, July, 1916). The patient was a fifth child, but no history of a similar affection in any other members of the family could be obtained. A bullous eruption was noted when the child was nine days old. At the time of examination there were a few small dry crusty spots on the scalp, and some scratch marks partially covered by crusts on the face. On the elbows there were inflamed, oval, violaceous areas covered by fine dry scales. There was also a bleb. The skin of the hands and fingers was wrinkled and atrophic, and there was some infiltration on the palmar surface. A large bulla, containing straw-coloured fluid, was present on the knuckle of the left index finger. There was complete absence of all finger nails and atrophy of the matrices. The skin of the chest and abdomen was dry and mottled, and signs of recent bullous lesions were detected on the back, knees, legs and feet. The toe nails were also absent. The Wassermann test proved negative. The author regards the case as one of the second or dystrophic group of epidermolysis bullosa. The first group or simple form of the disease is usually congenital and often hereditary. The bullae appear in any part of the body after the skin has been subjected to mechanical irritation or trauma. Mucous membranes are seldom affected, and the lesions heal without scarring. The second or dystrophic group is less frequently hereditary. The bullae appear at or shortly after birth, especially on the extremities. There is a great tendency for the contents of the bullae to be hæmorrhagic. The lesions are frequently symmetrical, and crusts and scabs form after the collapse of the blebs. Ulceration occurs occasionally. Atrophy of the skin and degeneration of the nails frequently occur. The enamel of the teeth may be defective. The mucous membranes are often involved. In regard to the causation of the condition, Elliott has attributed it to excessive congenital irritability of the vascular supply of the skin, while Engman and Mook refer it to the absence or deficiency of elastic tissue in the upper and papillary portions of the derma. Kaposi, Lustgarten and Ravogli have expressed the opinion that epidermolysis bullosa has the same pathology as urticaria. The author suggests that syphilis may play an ætiological rôle.

(152) Keratoderma Blenorrhagica.

E. G. Graham Little and P. A. Hayne record a severe case of keratoderma blenorrhagica in a married man, aged

56 years (*Proc. Royal Society of Med., Dermatological Section*, June, 1916). The history given was as follows:—In 1889 the patient had an attack of urethritis, followed by arthritis of the left knee. An eruption of warty, brown excrescences appeared on the feet. The excrescences were said to have been "as big as buttons," and to have dropped off. In 1896 he had a severe urethritis, and the urethral symptoms, including discharge, scalding and pain, recurred in 1913. Two years later he felt seriously ill, and was very wasted. The left knee, left foot, right knee and right foot became affected in turn. In January, 1916, he was forced to take his bed, and about four weeks later an eruption of hard, waxy, brownish yellow scabs appeared. The man was profusely cachectic, and there was a sickly odour of a chronic septic condition. The skin was dry, thin, and of an "old ivory" colour. The knee and interphalangeal joints were acutely swollen and red, but the inflammation cleared up after two injections of a gonococcal vaccine. On the soles of both feet there were heaped up masses of hard, horn-like material. When these masses were shed a reddened, dry, scaly surface, with a sharp line of demarcation, was left. Similar smaller masses were distributed on the legs, thighs, arms, hands and scalp. In the interdigital sulcus there was a large suppurative lesion. Staphylococci, but no gonococci, were discovered in the waxy masses. The breath was very foul and the teeth dirty. The gums were puffy and swollen and exuded pus. On treatment this condition cleared up. The Wassermann reaction was negative. The patient was still extremely ill at the time of reporting.

(153) Naevus Anaemicus.

John Lane reports a case of *naevus anaemicus*, a condition first described by Vorner, in 1906 (*Journ. of Cutaneous Diseases*, August, 1916). The patient, a female, æt. 30, presented herself with chronic paronychia. The Wassermann reaction was negative, and there was a moderately enlarged thyroid. During the course of the examination six small white spots were noted on the right cheek. They were all somewhat circular in shape, with irregular borders, and varied from a half to one centimetre in diameter. The surrounding skin was normal, except for telangiectasis at the border of the largest spot. On the affected areas the hairs and sweat-pores were normal, while sensation was undisturbed. The skin of the spots themselves, except for colour, was unaffected. They were distinctly noticeable when the face was flushed by heat, exertion, or blushing, but at other times they were hardly perceptible. The diagnosis has to be made mainly from *albinismus partialis*, which is also a congenital affection, but in this there is an absence of pigmentation in the affected areas. Other conditions which may resemble *naevus anaemicus* are acquired, so that they can usually be distinguished by the

history. The pathological condition shows, according to Vorner, a diminution in the size of the blood vessels and sweat glands, whilst the swollen arteries have the structure of capillaries. He concluded that the condition was due to the inability of the vessels to dilate. Fischer, however, found no abnormality in the structure of the skin, and considered the condition to be functional, and due to a sluggish response of the vessels in limited areas.

(154) The Dermatologist, the proper teacher of Syphilis.

In a clear and concise address, delivered at the fortieth annual meeting of the American Dermatological Association, Joseph Zeisler (*Journ. Cutaneous Diseases*, August, 1916) states that the dermatologist is pre-eminently the person in whose hands the teaching of syphilis should remain. Although recent progress and discoveries in this field have been made by scientists outside of the department of dermatology, and for the most part outside of medicine in general, yet the work in confirmation and elaboration of it has been carried out by the dermato-syphilitist. Is it no longer necessary to have the trained dermatologist capable of recognizing the many and varying clinical appearances of this protean disease, and differentiating from similar and ambiguous lesions of other diseases? Or is the diagnosis to be left to the pathologist, based on a test which is not always reliable and infallible? The instructor in syphilis should be the man who possesses a knowledge of the recent advances, but has not forgotten the old traditional treasures. These qualifications are alone held by the best dermatologists, who have been amongst its pathfinders, its teachers, and its earnest workers. Are we unmindful of the work of Unna and Auspitz on the primary lesion? Have we yet forgotten the work of such dermatologists as Kaposi, Fournier, Leloir, Taylor, Hutchison, Schwimmer, Neisser, Hallopeau, Fordyce and others on syphilis? There are serious objections to the establishment of an independent department of syphilis in medical schools. Every department should retain its proper limited individual interest in the subject, but the bulk of the teaching, the history, the general pathology, serology, and the treatment should remain with the chair of dermatology. The inception and further phenomena in untreated cases are predominantly upon the integument and mucous membranes, and the later lesions would for the most part be avoided, provided the patients come under the observation and treatment of the dermatologist at this period.

(155) Fournier's Secondary Syphilitic Analgesia.

C. Rasch records the case of a young girl, aged 21, who was admitted to hospital with syphilis (*Brit. Journ. Dermat.*, April-June, 1916). She was treated by mercury inunctions. Five months later she reappeared with an

ulcer in the fauces, and was again treated by inunction. A few months later some ulcerated sores appeared on the forehead, and the patient suffered from headaches, falling of hair, loss of weight and inability to take food. She improved under potassium iodide and iron. On close examination it was found that a pronounced analgesia and some anaesthesia were present on the dorsal surfaces of both hands and on the mammae. The discovery of these Pournier's areas caused the author to have a minute neurological examination of the patient carried out, as a result of which the absence of the patellar reflexes, with a persistence of the Achilles tendon reflexes, were noted. These signs indicated an affection of the nervous system.

BIOLOGICAL CHEMISTRY.

(156) Growth of Chicks in Laboratories.

J. C. Drummond has found it impossible to rear young chicks kept under the artificial conditions of the pens at the Research Institute of the Cancer Hospital, London (*Biochemical Journal*, March, 1916). He issues a warning against deducing results from experiments on feeding experimental animals on different diets unless the control animals, when fed in the usual way, grow in a normal manner. He shows that young chicks, fed on a diet which would suffice to produce satisfactory development in better surroundings, suffer from severe forms of malnutrition when kept in the laboratory. The difficulty of raising young chickens indoors has been realized by poultry-farmers, who seldom attempt to carry out this project. No deficiency in diet can be held responsible, since the chickens kept in the pens in the animal house have been fed on the same food that serves for the satisfactory development of chickens housed in the open air. The replacement of the sand, sawdust and broken shell on the surface by earth and grass fails to remedy the condition. The chickens scratch over the earth, pick out the small insects and feed throughout the day, but they grow little better than chicks reared on a surface of sand and grit. It is obvious that some other factors besides diet are needed to ensure the growth of the chickens. By bringing batches of chickens into the laboratory at different ages it has been found that the younger chickens have died sooner than those older. Chickens six weeks old live longer than those brought in earlier, but these older chickens become ill-nourished and fail to reach maturity. After a time, the chickens cease to increase in weight. In this condition they may survive for weeks, when they decline and die. During the course of the investigation it has been found possible to maintain at a constant weight for 80 days a chick weighing 150 gm. on a diet of unpolished "red" rice. The author considers that many experiments such as those of Funk and of Funk and Macaluso have a much less value when subjected to criticism on the lines of these studies.

(157) Glycaemia and Glycosuria in the Bengali.

D. McCay, S. C. Banerjee, L. M. Ghosal and M. M. Dutta have been engaged on an inquiry into the causes of the prevalence of diabetes in India (*Indian Journ. Med. Research*, July, 1916). They have made observations on the amount of sugar in the blood and on the quantity of sugar in the urine in various conditions of health in the Bengali. They have estimated the concentration of glucose in the blood by means of a modification of the method of Shaffer. In 50 Bengalis of average health and appearance the limits of the range of sugar in the blood have been 0.087% and 0.2%, the average has been 0.13%, while, in 27 individuals, the percentage has been less than 0.12%, and, in 23 persons, it has been more than 0.12%. In none of these persons has the urine shown a trace of reduction with Fehling's solution or a positive Benedict's test. The absence of any clinical signs of sugar in the urine, voided at the time that the sample of blood has been collected, has been accepted as an indication that the percentage of sugar in the blood of the person examined is not above the normal limits. The concentration of sugar in the blood has been found to run parallel to the weight of the trunk of the body per foot. From observations on 30,000 Bengalis it is accepted that the average weight of the trunk is 41 lbs. per foot. When the weight of the individual is less than the average expressed in the above terms, the concentration of sugar is less than 0.13%, when the weight of the trunk is 52 lbs. per foot the sugar amounts to 0.14%, and when the weight is 64 lbs. per foot the percentage of sugar is 0.16. The investigators have examined the toleration of carbohydrates in these persons by administering considerable quantities of glucose by the mouth. The persons tested have been divided into two groups. In the first group those who have a weight of trunk less than 50 lbs. per foot and less than 0.13% of sugar in the blood are included. Enough glucose has been given to these persons by the mouth to raise the amount of glucose in the body by 2 or 3 gm. per kilogram of body-weight. Twenty-eight persons have been tested in this way, with the result that a trace of glucose has appeared in the urine of three. The remainder have thus shown a high tolerance of glucose. In the second group are included those with a weight of trunk of more than 50 lbs. per foot and a concentration of sugar in the blood greater than 0.13%. The administration of rather less glucose by the mouth produced glycosuria in eleven out of fifteen persons. In those persons who became glycosuric the concentration of sugar in the blood has been increased by the dose of glucose. In consequence of these results, the authors have adopted the practice of giving 40 gm. to 60 gm. of glucose to patients and of estimating the concentration of sugar in the blood before and after the administration of the glucose. When there is an increase in the amount of sugar in the blood of

0.01% or more, the patient is regarded as potentially diabetic. A table giving the results from 61 cases in which this test has been used is recorded.

(158) Iodine in Foods.

E. B. Forbes and F. N. Bergie, with the collaboration of C. M. Fritz, L. E. Morgan and S. N. Rhue, have tried to ascertain whether or not there is a difference between the iodine content of food in areas where goitre is prevalent as compared with areas where goitre is rarely seen in the United States of America (*Journ. Med. Research*, July, 1916). They are of opinion that there is a tendency for the thyroid gland to enlarge at the period of adolescence, and that this tendency is counteracted by the presence of sufficient iodine in the food. The method for detecting and estimating iodine is described in detail, and attention is paid to the conditions requisite for obtaining accurate results. The number of samples examined has totalled 878, and iodine has been found in 197 samples of food. The foods have been purchased in the ordinary way, or obtained from agricultural experimental stations. The foods have been collected from regions where goitre is prevalent, and from areas in which it is rare. Many samples have been taken at farms in which members of the proprietor's family are affected with goitre. The data collected show that iodine is by no means a constant constituent of foods. It should be regarded as an accidental constituent, dependent on the nature of the soil. No difference could be noted, either in the distribution or amount of iodine in foods derived from districts in which goitre is prevalent. Iodine only exists in traces in animal products, and has been absent from 24 out of 35 samples. Iodine is uncommon in cereals, being present in traces in 60 out of 378 samples. Garden vegetables contain iodine rather more commonly, in 39 out of 131 samples. In some cases the amount present has been large. Agar-agar and Irish moss contain large amounts of iodine, much more than any other food examined. The foods produced in certain areas invariably contain iodine, e.g., in some parts of Kansas.

(159) Estimation of Calcium.

E. Cahen and W. H. Hurteley have devised a new method for the estimation of calcium (*Biochemical Journal*, June, 1916). The method has been used to determine the quantity of calcium in the walls of the aorta and in organs such as the heart. The tissue is dried and calcined. It is then treated with phosphoric acid, which dissolves all the calcium. The solution formed in this way can be used directly for volumetric estimation, or can form the basis for a gravimetric measurement. The addition of oxalic acid, followed by ammonia, to the solution yields a crystalline precipitate of calcium oxalate. No difficulty has been experienced in separating calcium from magnesium by this method.

British Medical Association News.

SCIENTIFIC.

A meeting of the New South Wales Branch was held at the B.M.A. Building, 30-34 Elizabeth Street, Sydney, on October 20, 1916. Dr. Sinclair Gillies, the President, in the chair.

The discussion on Dr. E. H. Molesworth's paper on "The Incidence of Venereal Disease and Methods of Prevention" (see *The Medical Journal of Australia*, September 23, 1916, p. 243 *et seq.* and pp. 261-263), and on Dr. J. B. Cleland's paper on "Some Social and Biological Aspects of the Venereal Diseases Question" (see pp. 359-360 in this issue) was resumed.

Dr. Richard Arthur, M.L.A., read a paper on "Some Aspects of the Venereal Problem" (see p. 361).

Dr. A. A. Palmer complimented Drs. Molesworth, Cleland and Arthur on their illuminating contributions to the subject. Dr. Arthur was supremely optimistic, and his paper cheered him up. He admitted that he was usually not inclined to take so hopeful a view of this matter. Referring to Dr. Molesworth's paper, he expressed himself in agreement with the author that the majority of cases of infection were contracted from the amateur, the "square girl," as Dr. Molesworth termed her. He did not agree, however, with the statement that this was a recent development. He had had a considerable number of young men to treat for venereal infections during the course of his earlier professional life, and he could not remember a single instance in which one of them had admitted that he had been infected by a professional prostitute. There was another point of difference between Dr. Molesworth and himself. He considered that the Wade legislation had been productive of great good. Long before any legislative control was considered, solicitation of the most pestering type was rampant in Sydney. It was notorious everywhere. The Act had led to an immense improvement, and if solicitation had again become somewhat more common during recent times, this was probably due to a relaxation on the part of the police. Then there was the abolition of the brothels. He spoke feelingly and frankly on this subject. Years ago a house of ill-fame was placed next door to his own residence, and it was most objectionable. Anyone who had experienced the nuisance caused by the numerous brothels of that time would agree with him that great good had been done by the Act when they were closed.

In the next place, he turned his attention to the question of education. He asked Dr. Molesworth to tell him who was to do the sexual education. Should it be the school teacher, or the clergyman? At what age should the boy be taught? What was to be taught him? Should they rely on preaching virtue and continence? He was cynical enough to be of opinion that this would not do much good. He regarded the matter as a very difficult one. It might be easy enough to talk about these things, but it was quite another matter to carry them out in real life. Dr. Palmer threw some doubt on the accuracy of the assertion that venereal diseases were on the increase. In any case he was convinced that any increase was not the result of legislative action. Dr. Molesworth had pointed out that the entrance of women into industrial life had contributed to the increase. It was probably true that the close association of men and women in the various callings had led to more promiscuous intercourse. In regard to alcohol, he was strongly of opinion that it had a great deal to do with venereal disease. In this he differed from Dr. Molesworth.

Dr. Palmer was in full accord with the provisions of the Western Australian Act, and more especially with that clause which rendered it an offence for anyone except a registered medical practitioner to treat a person suffering from venereal disease. He did not believe in applying a measure of this kind in a single State, and held that a similar measure should be brought in at once throughout the whole Commonwealth. In conclusion, he referred to Professor Welsh's remarks and his own experience concerning the curability of these diseases. The experience he had made in connexion with persons in gaol had proved to him that, occasionally, it was quite impossible to say when a man was cured of gonorrhoea. He had known the affection to reappear after the most careful examination

with the refined methods had failed to reveal any signs of infection.

Dr. C. W. Reid stated that his experience had taught him that venereal infections were conveyed by prostitutes. He had dealt with 260 cases from oversea ports, and in every instance the infection had been handed on by a professional prostitute. Early marriage had been suggested by Dr. Cleland as a remedy, but he ventured to doubt whether this would be effective. About 20% of seafaring men were married, and it was notorious that venereal disease was very prevalent among them. He advocated the use of preventive measures, and spoke in favour of imparting information to the growing youths of the community in regard to venereal diseases. He suggested that lock hospitals should be established, in order that a better control could be exercised over the patients. It was impossible to exercise any control over patients at venereal clinics. In his opinion, medical men should take boys to the lock hospitals and show them the results of venereal diseases. He was little hopeful that any means could be adopted which would improve the morals of the community. Preventive measures and publicity were more likely to cause a diminution of venereal disease than any preaching. He thought that ablutement tents had been of use in limiting the incidence of infection among the military. The prevalence of venereal disease in the Navy was one infection in each seven men, while in the Army it was one in five. The use of calomel ointment, as suggested by Metchnikoff, and of some weak antiseptic irrigating fluid had been proved to be efficacious.

Dr. A. J. Brady asked whether the contents of Dr. Arthur's delightful paper, which he summarized briefly in the sentence "Be good," was to be the message that the medical profession would give to the world? He was afraid that the world would take little heed of such a message. Dr. Arthur had approved of notification of venereal disease, but had declared that inspection of prostitutes had been proved to be a failure. Was there not some weakness, some contradiction in the argument? Dr. Molesworth had pointed out that the amateur was the greatest source of danger. This was unfortunate, but it did not necessarily signify that a control should not be kept on the professional prostitute. He would not admit that these diseases could not be prevented. In the past, the examination of the women had not been carried out properly. In certain cities where regulation of houses was carefully done, hygienists had found that there was small risk of infection. In Japan there was very little disease among the licensed women. He frankly advocated the recognition and regulation of brothels. In spite of Dr. Arthur's assertion that they had been of no use, he did not believe it. Dr. Brady deprecated the attitude taken up by some people who regarded venereal diseases as a just punishment for wrongdoing. At all events, doctors had discovered a great deal about these diseases within recent times, and they now knew how they could be prevented. Being in possession of this knowledge, he asked whether they were justified in withholding it from the public. They would not do so had venereal disease been an industrial instead of a social disease. The task of preventing yellow fever and malaria had been much more difficult. Both were much more insidious. If they were justified in recommending the application of kerosene to the breeding-places of mosquitoes, surely they were justified in recommending the use of calomel ointment. Dr. Arthur's high tone was most admirable, but he was afraid that his ideals were Utopian.

Dr. Brady was convinced that venereal diseases could be controlled by adequate inspection of both men and women and isolation of the infected. He claimed that, if he had the administration of public health in his hands without interference from outside, he could stamp out venereal disease from a community in five years.

Dr. Sinclair Gillies called the attention of the members to a memorandum of the Council on Venereal Diseases which had been drawn up in response to the publication of the Report of the Federal Departmental Committee's Report on the Causes of Death and Invalidity (Venereal Diseases). The memorandum had been published in *The Medical Journal of Australia* (October 21, 1916, pp. 246-247).

Dr. Ralph Worrall wondered whether the discussion was to be merely academic or whether a practical decision was

to be arrived at. Referring to Dr. Palmer's defence of the Police Offences Act, he wished to differentiate sharply between the wisdom of checking solicitation and that of closing brothels. He approved of the former cordially, but he maintained that brothels were beneficent, provided that they were not allowed to become a nuisance and that the proprietors were prevented from breaking the law (*e.g.*, in regard to the sale of alcohol, etc.). He was strongly of opinion that the Government should be urged to repeal that part of the Act which dealt with these houses. Dr. Arthur's proposals were idealistic, but impracticable. They did not yield an immediate solution of the problem. Dr. Schlink had suggested that clergymen might be required to assist in the education of the young in this connexion. Dr. Worrall considered that nothing could be more unwise than this suggestion. Boys would regard this form of teaching as just a moral lecture, and it would have no effect at all. He held that medical men should undertake the education in sexual matters. The boys would recognize that the doctor understood how to keep the body in health, and would therefore take their lessons to heart.

Dr. Worrall paid Dr. Molesworth a high tribute. He approved most heartily of his paper, and thought that no one should attempt to legislate in this direction without having read it. He did not agree with Dr. Molesworth regarding the rôle played by alcohol. He was convinced that many persons acquired venereal disease when under the influence of alcohol, who would not have exposed themselves to the risk had they been sober. He had had incontrovertible evidence of this in his practice.

He then turned his attention to the various panaceas which had been suggested as means to combat venereal infections. In the first place, there were the venereal clinics. He was sure that they would not exercise any appreciable influence on the spread of the diseases. They might have the effect of giving the patients a sense of security by the adequate treatment that was carried out. In the second place, there was early marriage. The incidence of venereal disease during prematurity was high. No one would advocate marriage before maturity had been reached. Moreover, the frequency of divorce was considerably higher among those who married very young than among those who married at a later date; it was out of all proportion. The third panacea was the teaching of the young. Medical students were undoubtedly best informed in regard to these matters, and they were notoriously unheeding of the dangers of promiscuous sexual intercourse. He might be asked what he would recommend, since all these proposals did not appeal to him. In the first place, he would sweep away the illegality of the brothel and the provisions regarding the detention of prisoners should be modified. In the second place, he advocated the use of the condom. He maintained that there was no other method which could remove the dangers so effectively and so surely as this. Neisser had stated that all other means were useless, and that the condom alone was reliable. The Federal authority should be approached with the object of having the restrictions placed on the importation of condoms removed. Chemists should be compelled to exhibit anti-venereal packets in their windows. These packets might contain the Rathbone pamphlet and a lesson on the wisdom of continence. If this lesson were unheeded, the purchaser would find a few condoms inside.

In the last place, Dr. Worrall replied to a question which had been put to him by a previous speaker in regard to the intensity of sexual appetite in the female. He regarded an unmarried elderly woman as an actual tragedy. Unmarried women aged much more rapidly than their married sisters. In a very large proportion, women had sexual desires which were easily excited. In a small proportion there was excessive desire, the suppression of which was more harmful and difficult than that in the case of the average man.

Dr. H. C. Adams regarded Dr. Arthur's views as ideal, but illusory. He was of opinion that the average man could not be rendered continent. His considerable experience of venereal diseases taught him that alcohol played a considerable part in the indirect causation. In England, the majority of infections were obtained from prostitutes, but in Australia the prostitute did not spread the disease to any extent. It was spread by the amateur. Continence

would never be attained among a considerable community of men. Men would obtain some form of sexual gratification, and he was therefore in favour of dealing with the matter from a hygienic point of view. He agreed with Dr. Worrall that brothels should be permitted to exist, and he held that it was extremely unwise to chase the prostitute from place to place. If it proved a nuisance for anyone to have a brothel next to his residence, it might be wise to reserve a part of the town for these houses. He also agreed with Dr. Worrall that, while many cases of infection would be cured at the clinic, this institution would not result in a reduction of infection. He spoke of the evidence which he had gathered in regard to the efficacy of calomel ointment and a simple antiseptic solution for urethral infection. He was convinced that the amount of venereal disease among our troops could have been lessened very considerably had every man received a packet containing preventives in Egypt and elsewhere. He admitted that it was useless providing these measures when men were indulging in alcohol, but in other cases they were of the greatest value.

Dr. D. Kelly pointed out that it had been stated that venereal diseases could be prevented quite easily. That might be true as far as the Army or the Navy were concerned, for the men were more or less under control. But the same could not be said of the general public. He did not think that the civil population could be induced to use condoms. He asked those who advocated preventive measures whether they expected that a young man would pack a bag with the necessary paraphernalia before going out for the evening. It must be remembered that, as a rule, he did not start from home with the object of indulging in sexual intercourse. He also wished to know how these precautions could be applied on the beaches.

Dr. Kelly referred to the matings of various lower animals, and compared their habits with those of human beings. He was convinced that the average woman desired sexual intercourse once she had "tasted blood." The man was somewhat like the bull, and needed to restrain himself at all times. Mental occupation was the best means of overcoming this impulse. Those employed physically had time to think over sexual matters, and the impulse was not counteracted. In conclusion, Dr. Kelly expressed himself in full agreement with all that Dr. Molesworth had said.

Dr. W. F. Litchfield read the recommendation of the Federal Departmental Committee's report dealing with continence, and pointed out that Dr. Arthur's views supported this recommendation, while Dr. Worrall's doctrines were directly opposed to it. There was obviously much difference of opinion among medical men on the subject. The position was so difficult that he thought they would be excused if they sat on a rail for the present. They should not do anything which might have the effect of doing away with moral control. He did not think that there was any necessity for the medical profession to send a message to the public, and, in any case, the profession was not unanimous and therefore was not in a position to do so. All they could do was to tell the public the facts. Perhaps the public might appeal for guidance later on, and then they would have to attempt to find a plan which would meet with general approval.

Dr. Sinclair Gillies held that sexual instincts could and should be controlled. In casting a glance over the various suggestions which had been made to meet the situation, he was inclined to believe that every one of them would be of use. But he was strongly of opinion that education was the most valuable of all the prophylactic measures.

Dr. Molesworth thanked the members for the kindly manner in which they received and handled his communication. He had been prepared for a great outburst of opposition. He would attempt to reply to the majority of the questions put to him.

Dr. Pockley had asked him whether he advocated the teaching of young boys in regard to preventive measures. He had not suggested anything of the kind. He would teach boys at a tender age that illicit intercourse was dangerous, and that it was not worth while. He would teach them this in class. He agreed with Dr. Cleland that a prostitute who had intercourse with a large number of men one after another could infect the greater number,

but this did not alter the fact that 60% or possibly 70% of the infected persons who obtained treatment at the night clinic had been infected by the amateur. His experience of man did not admit him to be as optimistic as Dr. Cleland was. He could not argue that man was monogamous. Perhaps he would become so in the future.

Replying to Dr. Schlink and Professor Welsh, he was opposed to the proposal to bring in the clergyman and others associated with religious bodies for the purpose of giving education to boys on sexual matters. In regard to his claim that students should have more direct teaching in these subjects, he maintained that Dr. Sandes's experience at examinations did not prove that the average student was capable of diagnosing syphilis from psoriasis. The student should have more actual clinical experience.

The difficulty of ascertaining when a cure had been effected had been spoken of by several members. In regard to syphilis, he was strongly of opinion that valuable information was obtainable by the "double test." A provocative dose of 0.3 gm. of salvarsan at times did not lead to a definite reply. But if a specimen of blood were taken before the provocative injection it was possible to compare the Wassermann tests before and after. He did not register a cure unless the hæmolysis progressed step by step without any difference in the two specimens.

Dr. Arthur had stated that registration of prostitutes had failed. He questioned whether this was so. In countries where registration was properly carried out the prostitutes in the brothels were comparatively safe. He was prepared to believe that the introduction of registration was not a practical proposal for Australia at the present time. He agreed that the condom and calomel ointment suggestions were admirable. He had been informed that a preventive packet, somewhat like the "Dreadnought" packet, could be sold at a profit for 1s.

He had been misrepresented in regard to his remarks about alcohol. He had not said that alcohol played no part in the spread of disease. What he had said was that it could not be blamed for the recent increase in prevalence. Similarly, he had not said that continence in men was impossible. He regarded continence as an individual virtue. It had no meaning when applied collectively to a community. Dr. Arthur's parallel of the shipwreck was not a real parallel. Discipline came into play. He doubted whether "women and children first" would obtain if the individuals were recruited haphazard from the general community. Dr. Arthur had spoken of prostitution for the gratification of women as an absurd suggestion, but it actually existed in some European cities. In regard to the double standard of morality, he claimed that there was a scientific basis for it. Sexuality in women was responsive rather than spontaneous. Temptation did not come with the same force to women as it did to men. Males had always insisted on obtaining sexual gratification, and always would. Dr. Molesworth suggested that the double standard of morality was a creation of women. Women did not look down on the male who indulged, but did look down on the "other woman." He illustrated his meaning by a reference to Japanese customs. He concluded this part of his reply by stating that the world must cater for those who can reason and also for the fool.

Dr. Palmer had spoken of the decrease in solicitation in the streets. Dr. Molesworth held that it was less noticeable and was not accompanied by so much pestering as formerly. But it still existed to a very great extent. He did not think that it was possible to prevent it, and, in view of the extent of amateur prostitution, he did not think that the gain would be great if it could be prevented. He adhered to his position concerning brothels, but admitted that it would be wise to segregate them.

Education must be carried out. All parents should face the problem as one of their most responsible duties. He would tell the child how flowers propagated their species, and teach the lesson of the union of the male and the female. Ultimately, these facts could be applied to the human being and a simple description of the act of coition should be given. This could be done between the ages of 12 and 14 years. From 14 to 16 the dangers of illicit intercourse should be spoken of. (A member interposed the remark that these lessons might be too late.) He would tell boys that many thousand people were crippled and killed by the

results of promiscuous sexual intercourse. He challenged Dr. Reid to disprove his doctrine about the danger of the amateur prostitute. Dr. Reid had dealt with a seafaring population. There was no parallel between seafaring people and the inhabitants of a large city. The lock hospital proposal was impossible, for in Sydney alone they would have to find accommodation for anything between 20,000 and 40,000 individuals.

In conclusion, he thought that the profession should importune the Government to cease harrying the prostitute, and that they should treat as many infected persons as they could. Syphilis at all events should be rendered notifiable, and the sale of condoms should be legalized.

The Referendum.

Dr. Sinclair Gillies called the attention of members to an advertisement in the *Journal* inviting contributions to assist the National Referendum Committee (New South Wales) in its campaign in favour of compulsory enlistment. He thought that an expression of opinion on this subject by the members assembled would be of value.

The following motion was carried unanimously on the proposal of Dr. R. H. Todd:—

That this meeting of the New South Wales Branch of the British Medical Association unanimously affirms its approval of the introduction of the compulsory military service overseas for the purpose of the present war, and looks forward with hope to the answer of the people of the Commonwealth in the Referendum vote to be taken on October 28, 1916, being "Yes."

Medical Societies.

(Affiliated with the British Medical Association.)

CENTRAL WESTERN MEDICAL ASSOCIATION.

A meeting of the Central Western Medical Association was held at the Town Hall, Parramatta, New South Wales, on September 20, 1916, Dr. O. E. Bruce Withers, the President, in the chair.

Mr. H. Richardson Clark, J.P., delivered an address on "The Coroner and the Doctors." In introducing his subject, Mr. Clarke, who is Coroner for Parramatta, gave an account of the office of coroner. He stated that the Common Law, as distinct from Statute Law, was brought from England to Australia with the first colonists. The office of Coroner in England was of great antiquity, but he was unable to give a satisfactory account of its origin. In the 18th century coroners existed, and were then judges, who presided at the trials of prisoners for crimes and over civil cases. Their powers were very much reduced in the time of King John, and they had been still further reduced up to the present time. In the reign of Edward I. they dealt with violent and sudden deaths, burglaries, rape, prison breach, wounds and treasure trove. At the present time in England the Coroner was restricted to enquiries into the cause of violent and sudden death and in the city of London into the circumstances attending fires. The same applied to the Coroner in Australia. No qualification was necessary, but many Coroners in the Commonwealth were solicitors.

The Coroner held two kinds of enquiries: an inquest and a magisterial enquiry. He was a magistrate according to Statute Law by virtue of his office. To hold an inquest it was essential that the body should be viewed. At an inquest the Coroner could commit a person for trial, which he could not do at a magisterial enquiry. The Coroner's Court was a Court of Record. Mr. Clark maintained that every Court of Record had power to punish for contempt of its authority, and to compel the attendance of witnesses. The Coroner had power to summon a witness, including a doctor, and if the summons be disobeyed he had power to issue a warrant to the police to bring the witness before him, and if any witness refused to answer a question, or having answered, refused to sign his deposition, the Coroner had power to commit that person to gaol, but he had no power to inflict a fine. Mr. Clark admitted that these powers did not arise under any Act of Parliament, but were derived from the Common Law.

He then turned his attention to the Coroners' Acts, and discussed some points in connexion with the calling of a jury. He also dealt with the law regarding the removal of the Coroner from his office.

The Coroner was required by law to hold an inquest in the following cases:—

- (1) Violent and unnatural deaths.
- (2) Casualties by which death ensues.
- (3) Persons dying in gaols.
- (4) Persons found dead.
- (5) Persons committing suicide.
- (6) Prisoners executed in gaols.
- (7) Deaths from accident in or upon mines.
- (8) Sudden deaths.

According to the instructions of the Attorney-General, the Coroner should hold an enquiry into the cause of death of any illegitimate child when no medical certificate was given, and the same usually applied in the case of a State child. He was also instructed to hold an inquest in every case of a death in a Government institution, such as an asylum for the insane. All deaths occurring in public hospitals from injuries received by accident or otherwise should, in the opinion of the medical adviser for the Government, be reported to the Coroner, whereupon the latter would exercise his discretion as to the necessity of holding an inquest. The secretary in charge of a public hospital should give timely notice to the Coroner or nearest to this officer of supposed criminal operations coming under notice at the hospital.

Mr. Clark gave it as his opinion that certificates of death were given by doctors in conformity with practice or custom universally adopted by doctors in compliance with the wishes of the Crown and as a matter of public policy. This matter did not come under any Act of Parliament. In guiding medical men in connexion with this matter, he stated that a doctor should not give a certificate of death in any of the cases in which the Coroner was authorized to hold an inquest, whether the doctor had attended the patient for the illness from which death ensued or not. The doctor should not give a certificate in a case when the person was dead at the time when he was first called in. These cases should be reported to the Coroner. He pointed out that it was an indictable offence in any person to bury the body of anyone who had died a violent death without the authority of the Coroner.

After quoting some of the provisions of the Coroners' Act, Mr. Clark proceeded by stating that the Coroner had power, apart altogether from the Coroners' Act, to summon a doctor, and if he refused to attend to issue a warrant for his attendance, and if he should refuse to answer a proper question on being brought before a Coroner, the Coroner had power to commit him to gaol for contempt of court.

In the next place he dealt with the procedure in the case of a death not certified by a doctor. Unusually the Coroner received a verbal report from a policeman. Instructions were then given to the policeman to see the doctor and to obtain a report as to the probable cause of death. If a doctor had not previously attended the deceased one was asked to examine the body and report. Some doctors, he stated, were under the impression that a Coroner was not justified in asking for a report in any case; but if the Coroner had to decide whether or not an inquest should be held, how could he do so unless he had a written or verbal report from the doctor? Should a doctor refuse to give a report, the Coroner would be bound to hold an inquest to obtain from him on oath his opinion as to the cause or probable cause of death. He quoted from a judgement of Lord Selbourne, Lord Chancellor, in which it was laid down that the Coroner could not properly exercise any discretion (in regard to the holding of an inquest) unless by enquiry or otherwise he had obtained such credible information as might be sufficient to satisfy a reasonable mind that death arose from illness or some other natural cause. The speaker thought that doctors, after hearing the statement of Law, would not refuse to make a report. He considered that, even when the Coroner determined to hold an inquest, a report would be of great assistance to him, as well as of convenience to the doctor if it were detailed. The deposition could be constructed beforehand, so that when the doctor was called to give evidence, he would not be detained long.

The fee paid to the doctor for report only was 10s., that for examination and report at the request of the Coroner and for giving evidence in Court £1 1s., that for giving evidence in Court only also £1 1s., and that for making a post-mortem examination £2 2s. The witness was paid 5s. a mile as mileage fee, or 1s. 3d. a mile, if the journey was made by rail.

Mr. Clark dealt with the question of the selection of the medical witness. In turning his attention to the determination to cause a post-mortem examination to be made he referred to the opinion expressed in Taylor's "Medical Jurisprudence" to the effect that an inquest without a most careful external and internal examination of the body was a vain mockery fit only for a comic opera. Mr. Clark stated that there were many passages in this book in which the author expressed the contempt for the Coroner's Court and for the class of person appointed as Coroner. He disagreed with many of the criticisms.

Mr. Clark dealt in considerable detail with the subject of illegal operations. He submitted that it was the legal duty of any medical man who knew that an illegal operation had been practised upon a patient under his care to inform the police of it, more especially if he thought that the patient was likely to die. The City Coroner had brought the matter before the Attorney-General, and it was receiving consideration. The Council of the Political Labour League had passed a resolution to the effect that it should be made compulsory for doctors and nurses to give immediate information respecting all cases of illegal operations which came under their notice. As far as Mr. Clark was aware no doctor had ever been prosecuted for failing to report. He attributed this to the fact that in nearly every case the doctor had acted with honourable motives. He admitted that the doctor's position was one of extreme difficulty. He was called in to attend a person who was, he presumed in every case, an absolute stranger, and the patient, realizing the safety (which, however, was entirely unsupported by any legal principle or authority) of statements made by her to him, was frank. The doctor, being a man of honour, would shrink from breaking the confidence. Mr. Clark considered that it was public policy that should govern a doctor's actions. He recognized that medical practitioners did not take up that position, and that they said in substance that there was no legal duty and no moral duty on them to report.

Mr. Clark dealt with a case on which he had held an enquiry at Parramatta (see *The Medical Journal of Australia*, April 15, 1916, p. 325). In his remarks on this case he had said:—

I respectfully appeal to the medical profession of this district to report to me or to the police any case in which a doubt may be felt, as it is only natural to suppose that a woman, subject of it, (i.e., of an illegal operation), being either very ill or on her deathbed, would then probably make a disclosure; but even if she did not the doctor would have had the satisfaction of knowing that he had not helped unwittingly or innocently to conceal wrongdoing.

He referred to the action taken by the British Medical Association in this connexion and to the articles published in the *British Medical Journal* and *The Medical Journal of Australia*. He disagreed with the attitude of the Association. He also quoted the opinion expressed in Taylor's *Medical Jurisprudence*, which may be summarized as follows:—

There was no privilege attaching to statements made to a medical practitioner by his patient. The duty of the medical practitioner who knew or believed that he was in attendance on a patient on whom criminal abortion had been practised was to attend his patient to the best of his skill. The medical practitioner would probably not be liable to indictment for misprision of felony, an offence which was nearly obsolete, because he did not give information in a case in which he suspected that criminal abortion had been practised. The medical practitioner should use his discretion in determining whether to give information or not.

Mr. Clark regarded this opinion as a mere general abstract opinion. He quoted Mr. Justice Avery, who held that under certain circumstances it was the duty of the medical

man to communicate with the police for the purpose of assisting in the administration of justice. The learned Judge recognized that no one would wish to disturb the confidential relations which existed between the medical man and his patient, but he held that there were cases in which the desire to preserve that confidence must be subordinated to the duty which was cast upon every citizen to assist in the investigation of a serious crime. Mr. Clark also referred to the opinion given by the Lord Chief Justice to a deputation of members of the British Medical Association in England.

He next argued that although the expression "misprision of felony" had passed somewhat into desuetude, Lord Halsbury in his *Laws of England* dealt with it as an offence which still existed. After having discussed at some length the legal position of a medical man being party to the concealment of a crime he passed on to consider the subject from the moral side. The offence was very prevalent. As the country was losing so many of her fine men in the war, the question had become more serious. It was a subject that must be viewed with anxiety and severity. He thought that the conscience of the medical man would impel him to adopt a moral attitude and to report. He did not think that the fear of a speculative action being brought against a medical man should be an excuse for any man failing to do his duty.

In proposing a hearty vote of thanks to Mr. Clark for the great trouble he had taken in preparing his exhaustive address, Dr. Reginald Bowman said that Mr. Clark had not made it clear whether he was of opinion that a medical man should report the matter to the Coroner or to the police in the case of abortion when the woman was likely to die, whether he had undoubted knowledge that a criminal abortion had been performed or merely suspected this to be the case. Injury might be done to innocent persons if the latter course were followed. A medical man could not claim privilege if he reported merely on slight suspicions. In the instance quoted by Mr. Clark the only ground for suspicion was the septic state of the uterus and the reputed character of the nurse. These were quite insufficient for any practitioner to go upon. In very few of the cases with which he had dealt could a doctor say that he had direct evidence that a criminal offence had been committed. It was most important that the feeling that patients had from time immemorial entertained that their confidences would be held inviolate, should not be disturbed.

Dr. R. H. Todd, in seconding the vote of thanks, spoke as one who had been a Coroner and was a Lecturer in Medical Jurisprudence. He pointed out that he was in touch with the medical profession, and, though a Barrister-at-Law, had been in medical practice. Mr. Clark had raised a great many important questions, and his paper had covered much ground. He was to be thanked for making the position of a Coroner so clear to the meeting. Medical men, however, were not in accord with him in apparently holding that it was the duty of Coroners and doctors to set about catching criminals and hunting up suspected persons. That was the duty of the police. The office of Coroner was a judicial one, and it was unnecessary, and probably, in the long run, unwise for a Coroner to interest himself in the cases coming to him for inquiry otherwise than was required for the due performance of his judicial and administrative duties. It was natural that a Coroner, like any other public functionary, should magnify his office. No doubt it was proper he should do so, but not by going outside his province. It was very public-spirited of Mr. Clark to take such a great interest in the important subject of criminal abortion, but an aggressive attitude towards the medical profession, because practitioners held that it was their sacred duty to respect their patients' secrets, was uncalled for. Mr. Clark had referred to the procedure under the Coroner's Act for compelling the attendance of witnesses, and had pointed out that, as a Judge of a Court of Record, a Coroner had a power to issue Bench Warrants for the arrest of witnesses who failed to attend the Court when ordered to do so. It was true that a Coroner's Court was a Court of Record, and it was possible that the inherent powers of a Judge of such a court attached to a Coroner. It was doubtful, however, whether the power to issue a warrant was not taken away by the fact that the Coroners' Act prescribed a special procedure to be followed in the case

of a medical witness who has failed to obey the Coroner's summons or order. The Act provided for compelling the attendance of a lay witness by the service upon him of a subpoena; but in the case of a medical witness the document to be served was an order or summons, and a penalty for neglect to obey was made recoverable in a summary way before Justices of the Peace. In any case it was better that a Coroner should assume that the medical witness had the same interest in the administration of justice as he had, and that his failure to obey the summons was due to some good cause over which he had no control. In regard to the question of its being the legal duty of the medical attendant to give information to the police if he suspected that his patient's illness resulted from some criminal act, no doubt Mr. Clark had made out a case which would carry weight with laymen. Before, however, the British Medical Association or Mr. Justice Avery existed, and for thousands of years farther back, even before the days of Hippocrates, it had been the tradition of medical practitioners that they should respect the secrets confided in them by their patients. It might be that a medical attendant who failed to do what Mr. Clark claimed he ought to do rendered himself liable to a charge of misprision of felony, but if it were so it would be deplorable, in the public interest, if the law were ever enforced. It was understood that when Mr. Justice Avery made the statements referred to, the case to be tried was not misprision of felony, but something else. They were not made in the course of a considered judgement but in addressing a grand jury on the question of an indictment.

Public Health.

THE HEALTH OF NEW SOUTH WALES.

The following notifications have been received by the Department of Public Health, New South Wales, during the week ending October 14, 1916:—

| | Metropolitan District. | | Hunter River District. | | Rest of State. | | Total. | |
|---------------------|------------------------|-------|------------------------|-------|----------------|-------|--------|-------|
| | Cs. | Dths. | Cs. | Dths. | Cs. | Dths. | Cs. | Dths. |
| Enteric Fever .. | 1 | 1 | 4 | 1 | 5 | 0 | 10 | 2 |
| Scarlatina .. | 54 | 0 | 9 | 0 | 12 | 1 | 75 | 1 |
| Diphtheria .. | 39 | 2 | 4 | 0 | 38 | 1 | 81 | 3 |
| C'bro-Spin'l Menin. | 3 | 3 | 0 | 0 | 4 | 1 | 7 | 4 |
| Pul. Tuberculosis.. | 23 | 9 | 0 | 0 | 1 | 1 | 23 | 9 |

† Notifiable only in the Metropolitan and Hunter River Districts.

THE HEALTH OF VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the week ending October 15, 1916:—

| | Metropolitan. | | Rest of State. | | Total. | |
|-------------------------|---------------|-------|----------------|-------|--------|-------|
| | Cs. | Dths. | Cs. | Dths. | Cs. | Dths. |
| Diphtheria .. | 62 | 2 | 29 | 2 | 91 | 4 |
| Scarlatina .. | 31 | 0 | 20 | 0 | 51 | 0 |
| Enteric Fever.. | 1 | 0 | 2 | 0 | 3 | 0 |
| Pulmonary Tuberculosis | 26 | 7 | 15 | 10 | 41 | 17 |
| C'bro-Spinal Meningitis | 7 | 0 | 0 | 0 | 7 | 0 |

INFECTIVE DISEASES IN QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ending October 14, 1916:—

| Disease. | No. of Cases. |
|---------------------------|---------------|
| Varicella .. | 23 |
| Erysipelas .. | 5 |
| Pulmonary Tuberculosis .. | 11 |
| Diphtheria .. | 23 |
| Scarlatina .. | 5 |
| Enteric Fever.. | 4 |

THE HEALTH OF TASMANIA.

The following notifications have been received by the Department of Public Health, Tasmania, during the week ending October 14, 1916:—

| Disease. | Hobart. Cases. | Launceston. Cases. | Country. Cases. | Whole State. Cases. |
|-------------------------|-------------------|-----------------------|--------------------|---------------------------|
| Diphtheria | 5 | 7 | 22 | 34 |
| Enteric Fever.. .. . | 1 | 0 | 1 | 2 |
| Pulmonary Tuberculosis | 1 | 0 | 6 | 7 |
| C'bro-Spinal Meningitis | 1 | 0 | 1 | 2 |
| Scarlatina | 0 | 0 | 1 | 1 |
| Puerperal Fever | 0 | 0 | 1 | 1 |

Naval and Military.

It is with great regret that we learn that Major W. Edgeworth David, who is serving as geologist to the New South Wales Mining Corps, has been injured. A message has been received in Sydney to the effect that he is suffering from scalp wounds and a broken rib, as a result of a fall down a vertical shaft 70 feet deep.

It is satisfactory to record that the 236th list of casualties, issued on October 18, 1916, and the 237th list, issued on October 22, 1916, do not contain the names of any medical men.

The following is an abstract from a letter addressed by the Principal Medical Officer of the 4th Military District to the Honorary Secretary of the South Australian Branch of the British Medical Association:—

It is desired to bring under the notice of your Association the terms and conditions under which members of the medical profession are granted honorary commissions on the Australian Army Medical Corps Reserve, especially during time of war.

A.A.M.C. Standing Order reads as follows:—

"In time of war all members of the A.A.M.C. Reserve are liable to be called out for military service."

It is not intended to enforce this regulation unless, and until, the District Medical Committee appointed under War Service Regulation (32) (1) has considered the case of any medical officer who has not voluntarily agreed to be called up for duty at the discretion of the P.M.O.

Should a medical officer not abide by the decision of the District Medical Committee in the matter of being called up for duty on home service, steps will be taken to remove the medical officer from the Military Forces List.

It is further intended that every consideration shall be given to each case, and that medical officers shall not be called up for any lengthy periods. Hitherto, the practice has obtained of utilizing officers' services for about a month continuously, but the necessities of existing war service considerations will demand a greater call on all medical officers' services.

Obituary.

HAROLD KNOWLES BEAN.

Harold Knowles Bean was born near Manchester, in England, about 60 years ago. He was the son of Dr. Bean, of Mosley. His medical education was undertaken at Edinburgh University, where he graduated in 1880. In 1881 he took the degree of B.Sc. (Public Health), and in 1884 he obtained his doctor of medicine. From the time of graduating until 1887 he assisted his father in his practice, and then came out to Australia. In October, 1887, he started in practice in Heidelberg, in Victoria, where he stayed two years. He married in 1889, and, before settling down, took a trip to England. On his return he settled at Wallsend, in New South Wales, and built up a valuable practice. He volunteered for service during the Boer War, and was attached to the Fourth Regiment as regimental surgeon. After having seen some fighting, he contracted pneumonia and was invalided home. Early in the present war he again offered his services to his country. He was given charge of the Second Queensland Light Horse Field Ambulance,

and accompanied our troops to Egypt. He was in Gallipoli for a time. His health failed him again, and he was invalided to England on account of an attack of appendicitis in November, 1915. After he had recovered he was again sent to Egypt, where he had charge of the Third Light Horse Field Ambulance. While serving in this capacity he suffered a cerebral hemorrhage or some other form of seizure, and, as reported in our issue of last week, succumbed to this illness after several months of suffering. During the Boer War he held the rank of Major, but since leaving Queensland for Egypt he has held the rank of Lieutenant-Colonel.

As a civilian practitioner he attained great popularity, and his practice was very extensive. He was a hard worker, and never considered himself in his endeavours to do good to others. As is usual under these circumstances, many took advantage of his kindness of heart and sought his assistance on every conceivable occasion. His patients held him in high esteem, and his colleagues and friends learned to value him as a man, a comrade and adviser. He held the position of Honorary Medical Officer to the Wallsend Hospital, and earned a great reputation as a surgeon at that institution.

NORMAN WALFORD BROUGHTON.

The death at an early age of men in the service of Empire has become a daily occurrence, but the frequency of this occurrence does not rob the fact of its significance, nor does it lessen the loss to those who remain. Norman Walford Broughton was a very promising young Sydney graduate, and, during the course of his student career, he earned the affection and respect of his comrades. He was immensely popular, and the short record that he obtained the degree of M.B., Ch.M., at the Sydney University in 1915 and was registered in May of that year in New South Wales as a legally qualified medical practitioner does not convey anything of the real impression which he left on those who sat by his side in the lecture theatres, on those who met him in the various fields of sport or on those who had the privilege of teaching him and equipping him for the stern fight of life. Immediately after graduation he responded to the call of the War Office, and obtained a commission in the Royal Army Medical Corps. He served as Lieutenant in France, where his manly bearing and general ability obtained for him promotion to the rank of Captain in July of the present year. In September he was "killed in action." Another life wasted through the wickedness of war!

JOHN EBENEZER DONALDSON.

The news of the death of John Ebenezer Donaldson has caused another thrill among the men at the Sydney University. In these days, when every young medical man with grit, knowledge and keenness is wanted for the Army Medical Corps, we cannot but feel that the Principal Medical Officer of the No. 2 Military District acted unwisely in allowing himself to be persuaded to consent to the transfer of this fine officer from the Army Medical Corps to the combatant service.

John Donaldson was educated at the Sydney Grammar School, and studied medicine at the Sydney University. He worked well and played well, and gained the respect and admiration of all with whom he came in contact. He distinguished himself as an intelligent student of medicine, and gained honours as an oarsman and boxer. In 1911 he took his degrees and then served as Resident Medical Officer at the Children's Hospital, at the Coast Hospital and at the Royal Hospital for Women. He was still engaged in hospital work when war broke out, and his friends were not in the least surprised when he volunteered for service and joined the Expeditionary Force which sailed to New Guinea. He was then in the Australian Army Medical Corps, and was present at the taking of Rabaul, when brave Pockley fell. After the short period of activity, there was a long spell of "nothing doing." He returned in due course to Sydney, and by dint of his importunity he was transferred from the medical to the combatant service. He obtained a commission and was gazetted to the 19th Battalion of the 2nd Australian Division. His unit arrived at Anzac in August, 1915, very shortly after his brother had been killed in action at Lonely Pine. He saw some fierce fighting,

more especially at Suvla Bay, and was fortunate in escaping the Turkish bullets. During the Gallipoli campaign he fell sick, but was soon on the active list again. The evacuation brought his battalion first to Egypt and subsequently to France. It appears that he took part in the fighting at Armentières, and he must have experienced many of the horrors of the Somme "push." During these operations, when the British checked the progress of the Germans and drove them back, slowly but surely, he paid the full price. Those who saw him on the field always found him modest, cheerful and yet determined. He was a man to be proud of. By courage, coupled with a high sense of duty, he has earned his place in the Roll of Honour.

Books Received.

DAMAGED GOODS: A Play by Brieux, Member of the French Academy. Translated by John Pollock, with a Preface by Bernard Shaw and a Foreword by Mrs. Bernard Shaw; Demi Svo., pp. 68.
OPERATIVE MIDWIFERY, by Harry Sturgeon Crossen, M.D., F.A.C.S., 1915. St. Louis: C. V. Mosby Company; Australasian Agents: Stirling & Co., Melbourne; Royal Svo., pp. 670, with illustrations. Price, 35s.
OPERATIVE SURGERY OF THE NOSE, THROAT AND EAR, by Hanau W. Loeb, A.M., M.D., in collaboration with Joseph C. Beck, M.D., R. Bishops Canfield, M.D., George W. Crile, M.D., Eugene A. Crockett, M.D., William H. Haskin, M.D., Robert Levy, M.D., Harris P. Mosher, M.D., George L. Richards, M.D., George E. Shambaugh, M.D., and George B. Wood, M.D.; Vol. I, 1914. St. Louis: C. V. Mosby Company; Australasian Agents: Stirling & Co., Melbourne; Royal Svo., with 400 illustrations. Price, 52s. (two volumes).

Medical Appointments.

Dr. R. N. Wawn has been appointed Acting Officer of Health for Prahran City during the absence of Dr. R. H. Fetherston on military duty.

Dr. W. C. Marsden has been appointed Officer of Health for the Belfast Shire, Victoria, in place of Dr. N. Pern, resigned.

Dr. A. P. Langley has been appointed Officer of Health for Ferntree Gully Shire, Victoria, in place of Dr. D. Simpson.

Dr. J. V. Heily has been appointed Officer of Health for the Central District, and Dr. W. E. Brunskill for the Eastern District of the Waranga Shire, Victoria.

Dr. A. W. Campbell has been appointed Honorary Neuro-Pathologist to the Coast Hospital at Little Bay, New South Wales.

Medical Appointments Vacant, etc.

*For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xvii.

Royal Australian Naval Medical Service, Temporary Surgeons.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.

VICTORIA.

(Hon. Sec., Medical Society Hall, East Melbourne.)

SOUTH AUSTRALIA.

(Hon. Sec., 3 North Terrace, Adelaide.)

APPOINTMENTS.

Brunswick Medical Institute.
 Bendigo Medical Institute.
 Prahran United F.S. Dispensary.
 Australian Prudential Association Proprietary, Limited.
 National Provident Association.
 Life Insurance Company of Australia, Limited.
 Mutual National Provident Club.

The F.S. Medical Assoc., Incorp., Adelaide.

Branch.

APPOINTMENTS.

QUEENSLAND.

(Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)

Brisbane United F.S. Institute.

WESTERN AUSTRALIA.

(Hon. Sec., 230 St. George's Terrace, Perth.)

Swan District Medical Officer.
 All Contract Practice Appointments in Western Australia.

Department of Public Instruction—Appointments as Salaried Medical Officers, with duties which include the treatment of school children.

Australian Natives' Association.
 Balmain United F.S. Dispensary.
 Canterbury United F.S. Dispensary.
 Leichhardt and Petersham Dispensary.
 M.U. Oddfellows' Med. Inst., Elizabeth Street, Sydney.

NEW SOUTH WALES.

(Hon. Sec., 30-34 Elizabeth Street, Sydney.)

Marrickville United F.S. Dispensary.
 N.S.W. Ambulance Association and Transport Brigade.
 North Sydney United F.S.
 People's Prudential Benefit Society.
 Phoenix Mutual Provident Society.
 F.S. Lodges at Casino.
 F.S. Lodges at Lithgow.
 F.S. Lodges at Orange.
 F.S. Lodges at Parramatta, Penrith, Auburn, and Lidcombe.
 Newcastle Collieries—Killingworth, Seaham Nos. 1 and 2, West Wallsend.

NEW ZEALAND: WELLINGTON DIVISION.

(Hon. Sec., Wellington.)

F.S. Lodges, Wellington, N.Z.

Diary for the Month.

- Oct. 31.—N.S.W. Branch, B.M.A., Medical Politics Committee, Organization and Science Committee.
 Nov. 1.—Vic. Branch, B.M.A., Branch.
 Nov. 3.—Q. Branch, B.M.A., Branch.
 Nov. 9.—Vic. Branch, B.M.A., Council.
 Nov. 10.—N.S.W. Branch, B.M.A., Clinical.
 Nov. 10.—S. Aust. Branch, B.M.A., Council.
 Nov. 14.—N.S.W. Branch, B.M.A., Ethics Committee.
 Nov. 15.—North Eastern Med. Assoc. (N.S.W.).
 Nov. 15.—W. Aust. Branch, B.M.A., General.
 Nov. 17.—Q. Branch, B.M.A., Council.
 Nov. 21.—N.S.W. Branch, B.M.A., Executive and Finance Committee.
 Nov. 24.—N.S.W. Branch, B.M.A., Branch (Ordinary).
 Nov. 28.—N.S.W. Branch, B.M.A., Medical Politics Committee—Organization and Science Committee.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.

